



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Provider Enrollment

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Version	Date	Reason for Revisions	Completed By
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Section 1: Introduction

Note: For updates to information in this module, see [IHCP Banner Pages and Bulletins](https://in.gov/medicaid/providers) at in.gov/medicaid/providers.

To receive reimbursement for services covered under the Indiana Health Coverage Programs (IHCP), including Medicaid services, a provider must be eligible for enrollment and actively enrolled in the IHCP (*Indiana Administrative Code 405 IAC 1-1.4-3*). This module contains information about IHCP provider eligibility requirements as well as provider enrollment, profile maintenance, and revalidation procedures.

For information about IHCP-enrolled providers charging members for services *not* covered by the IHCP, see the [Charging Members for Noncovered Services](#) section.

IHCP Provider Enrollment Partner Agencies

The IHCP provider enrollment procedures are designed to ensure timely, efficient, and accurate processing of provider enrollment applications and updates to provider profiles (information on file with the IHCP for existing providers).

The IHCP partners with key agencies to perform provider enrollment tasks. The primary agencies and their roles in the enrollment process are as follows:

- DXC Technology, in its role as fiscal agent for the IHCP, performs the following provider enrollment functions:
 - Enrollment of all providers
 - Maintaining the provider profile with changes as reported and authorized by the Indiana State Department of Health (ISDH)
 - Processing enrollment and provider profile update requests
 - Verifying licensure and certification requirements
 - Assigning IHCP Provider ID numbers
 - Storing National Provider Identifier (NPI) and taxonomy information submitted by providers
 - Maintaining active, terminated, and denied provider files
 - Disenrolling providers at the direction of the Indiana Family and Social Services Administration (FSSA), ISDH, Indiana Professional Licensing Agency (IPLA), Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General (OIG), or Attorney General (AG) when such action is warranted
 - Maintaining provider-specific rate information as supplied by the rate-setting contractor
- The Indiana Division of Mental Health and Addiction (DMHA) certifies the following entities:
 - Community mental health centers (CMHCs)
 - Freestanding psychiatric facilities
 - Psychiatric residential treatment facilities (PRTFs)
 - Adult Mental Health Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW) service providers
 - Opioid treatment programs (OTPs)
 - Substance use disorder (SUD) residential addiction treatment facilities
 - Medicaid Rehabilitation Option (MRO) clubhouse

- The IPLA issues licenses and certifications for physicians, nurses, dentists, mobile dentists, podiatrists, chiropractors, therapists (speech, language, physical, and occupational), hearing aid dealers, optometrists, audiologists, pharmacies, home medical equipment providers, and health service providers in psychology. Licensed providers in state and out of state are subject to licensure requirements (see *405 IAC 5-1.4-3* for enrollment requirements).
- Motor Carrier Services of the Indiana Department of Revenue certifies for-profit intrastate common carrier transportation providers including ambulatory, nonambulatory, and buses. The U.S. Department of Transportation (DOT) certifies interstate common carriers. Providers must have Indiana Motor Carrier Services certification or DOT authority to be enrolled in the IHCP.
- Indiana Emergency Medical Service (IEMS) certifies ambulance and air ambulance carriers.
- The ISDH provides survey information for certain providers required to be licensed by the ISDH. These providers include hospitals, ambulatory surgery centers, long-term care facilities, home health agencies, rehabilitation facilities and agencies, hospices, rural health centers, laboratories, and end-stage renal disease (ESRD) clinics.
- The ISDH and the CMS certify providers for Clinical Laboratory Improvement Amendments (CLIA); CLIA certificates are updated by the CMS electronically on an ongoing basis.

Provider Classifications

The following are the four provider classifications used for enrollment purposes:

- **Billing** – A practitioner operating as an individual or sole practitioner, or an organization operating as a business entity, billing for services at a distinct location, with no rendering providers linked to the practice or entity.
- **Group** – A practice or business entity operating at a distinct service location with one or more practitioners (rendering providers) linked to a common taxpayer identification number (tax ID) for billing. Group providers must ensure that rendering providers are linked to each service location where they render services for the group practice.
- **Rendering** – A practitioner or other provider performing services for a group practice and linked to a common tax ID. A provider enrolled as a *rendering* provider under one or more groups at one or more service locations may also enroll as a *billing* provider at a different service location.
- **Ordering, Prescribing, or Referring (OPR)** – Practitioners who do not bill the IHCP for services rendered but may order, prescribe, or refer services or medical supplies for IHCP members. These nonbilling providers are required by the *Affordable Care Act* (42 CFR Parts 405, 447, 455, 457, and 498) to enroll in the Medicaid program to participate as an OPR provider.

Successful claim processing depends on accurate input of the billing or group provider information, as well as the rendering provider information, if applicable. See the [Claim Submission and Processing](#) module for more information about claim submission procedures.

Section 2: Provider Eligibility and Enrollment Requirements

Indiana Health Coverage Programs (IHCP) provider enrollment requirements are based on the type and specialty of the prospective provider (see the [Provider Type and Specialty Requirements](#) section) and on rules established under *Code of Federal Regulations 42 CFR 455*, *Indiana Code IC 12-15*, and *Title 405 Office of the Secretary of Family and Social Services*.

Federal regulations passed by Congress in 2010 include mandates meant to address concerns related to increased financial risk of fraud, waste, and abuse through claims submitted to Medicare, Medicaid, and Children's Health Insurance Program (CHIP). The regulations include enhancements to the screening requirements based on the level of financial risk to the program. Additional information about federal guidelines for provider screening and enrollment criteria is found in the [Federal Register, Volume 76, No. 22, Pg. 5862](#).

Conditions for Provider Enrollment

A provider is enrolled when the following conditions are met for the applicable provider type:

- The provider is licensed, registered, or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the Indiana Family and Social Services Administration (FSSA) or the Indiana State Department of Health (ISDH). See the [Maintaining Licensure and Certification](#) section for more information.

Note: Out-of-state providers are certified, licensed, registered, or authorized as required by the state in which the provider is located and must fulfill the same conditions as an in-state provider. The [IHCP Provider Enrollment Type and Specialty Matrix](#) at in.gov/medicaid/providers lists out-of-state provider document requirements for eligible providers, and indicates which provider types and specialties are ineligible for out-of-state enrollment in the IHCP. For information about IHCP billing and reimbursement for out-of-state providers, see the [Out-of-State Providers](#) module.

- The provider has obtained a National Provider Identifier (NPI), as described in the [National Provider Identifier Requirements](#) section (applicable for all healthcare providers; not required for atypical providers).
- The provider has completed and submitted either an electronic or paper version of the provider agreement and all other applicable sections of the enrollment application, including dated signatures, where applicable, as required by the FSSA. The [IHCP Provider Enrollment Transactions](#) page at in.gov/medicaid/providers includes enrollment information and a link to the Portal for online enrollment. Online transactions are preferred, but, for providers not using the Portal, the [Complete an IHCP Provider Enrollment Application](#) page includes *Indiana Health Coverage Programs Enrollment and Profile Maintenance Packets* (IHCP provider packets) that can be completed, printed, and submitted via mail.
- Provider types identified as needing to pay an application fee have paid the application fee for each service location they wish to enroll. A list of providers subject to the application fee can be found in the [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#), available at in.gov/medicaid/providers. See the [Application Fee](#) section for more information.

- Providers categorized as high-risk providers in the Medicaid program are required to obtain a fingerprint-based national criminal background check of any person who:
 - Holds at least a 5% ownership or controlling interest in a facility or entity
 - Is a member of the board of directors of a nonprofit facility or entity

For more information on the fingerprint-based background check for high-risk providers, see the [Fingerprinting and Criminal History Check](#) section.

- The outcome of unannounced site visits, performed pre- and post-enrollment for provider types considered at moderate or high risk for fraud, is successful.
- Participation in the Medicare program or the appropriate state's Medicaid program has been confirmed for out-of-state providers and designated provider types. See the [IHCP Provider Enrollment Type and Specialty Matrix](#) for a detailed listing, as some provider types require proof of participation in Medicare or the appropriate state's Medicaid program, and some may require both.
- The provider is eligible to participate in all applicable federal or state programs. Eligibility is verified by searching databases that include the TIBCO Managed File Transfer (MFT) sanction list, System for Award Management (SAM), Social Security Death Master File, and the List of Excluded Individuals and Entities (LEIE).

Application Fee

Designated providers are required to pay an application fee. The application fee is used for program integrity efforts. The [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#) indicates which IHCP provider types and specialties are subject to an application fee.

See the [Provider Enrollment Application Fee](#) page at in.gov/medicaid/providers for the correct application fee amount. The amount is set by the Centers for Medicare & Medicaid Services (CMS) and is subject to change annually.

The application fee must be paid electronically – either online or by telephone:

- To pay online, go to the [Provider Enrollment Application Fee](#) page at in.gov/medicaid/providers and click the **IHCP Bill Pay site** link to begin the payment process.
- To pay by telephone, call 1-800-457-4584. Press 2 to access provider services, and then press 3 to update enrollment information. Select the option to make an *Affordable Care Act* (ACA) enrollment payment and follow the instructions for using the Convenience Pay system.

Providers may pay the fee using a credit card, debit card, or electronic funds transfer (EFT) from a checking account. Contact Customer Assistance toll-free at 1-800-457-4584 for assistance with the online payment system.

Proof of payment must accompany the enrollment application. Providers receive a confirmation number when the electronic payment has been accepted. Write the confirmation number in the appropriate field of the Portal enrollment application or the *IHCP Provider Application Fee Addendum*, which is included in the IHCP provider packet.

Application Fee Exemptions

Physicians, nonphysician practitioners, and some medical groups and clinics **are not required to pay an application fee**. See the [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#) to confirm whether an application fee is required for a specific provider type and specialty.

Providers that are enrolled in Medicare **are not required to pay an application fee** to Medicaid.

Providers that are enrolled in another state's Medicaid program, and have already paid an application fee to the other state's Medicaid program, **are not required to pay the IHCP**, but they must submit proof of that payment with their application. If the enrollment is pending, the application fee will be required.

Hardship Exception

Federal regulation includes provisions that allow providers to apply for a **hardship exception** to the application fee, on a case-by-case basis, based on circumstances that are appropriate to the provider's respective situation.

Any providers that believe they should be entitled to a hardship exception from the application fee should enclose a letter with their enrollment packet explaining the nature of the hardship and all steps taken to try to raise the required fee from other sources, such as loans, grants, and so forth.

Note: If a hardship exception is requested, the provider's application will not be processed until a decision is made by the CMS to grant the exception.

If the hardship exception is not granted, the provider has 30 days from the date on which the notice of rejection was sent to pay the required application fee.

Risk Category Requirements

All provider specialties are assigned a risk level: high, moderate, or limited. See the [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#) to identify the risk level for a given provider specialty.

Note: A provider's risk level can be modified to a higher risk level on an individual provider basis. Imposition of a payment suspension or an outstanding overpayment raises the provider's risk level to high.

All provider enrollments designated as **limited risk** are subject to standard screening activities that include the following:

- Verification of provider-specific requirements
- License or certification verifications
- Database checks for identity verification, exclusions, and restrictions

Screening for providers designated as **moderate risk** includes the "limited risk" screening requirements, plus unannounced pre-enrollment and post-enrollment site visits. See the [Site Visits](#) section.

Screening for providers designated as **high risk** includes the "limited risk" and "moderate risk" screening requirements, *plus* submission of fingerprints for a national criminal background check on individuals with at least 5% ownership or controlling interest in the business entity. See the [Fingerprinting and Criminal History Check](#) section.

Site Visits

Upon receipt of an enrollment packet from a provider categorized as moderate or high risk, an IHCP representative will make an unannounced pre-enrollment site visit to verify that the information submitted is accurate and to determine compliance with federal and State enrollment requirements. After enrollment has been activated, an unannounced post-enrollment site visit will be conducted within the first year. Failure to permit access to provider locations for any site visits will result in denial or termination of enrollment (42 CFR 455.416).

Fingerprinting and Criminal History Check

Providers categorized as high risk must undergo a fingerprint-based criminal background check through the State-authorized vendor. For any provider in this category, criminal background checks are required for any person with a 5% or greater direct or indirect ownership or controlling interest in the business, including the board of directors if the business is a nonprofit entity.

When scheduling the fingerprinting, it is important to choose **Family & Social Services Administration** as the *agency type* and **FSSA Affordable Care Act** as the *applicant type*. Other choices will require repeating the process. The confirmation number providers receive at the fingerprint collection center must be provided as proof of compliance. The IHCP provider enrollment packets and the Portal provider application include fields for fingerprint confirmation numbers.

All affected newly enrolling providers and providers revalidating their enrollments must comply with this requirement at the time their application is submitted. Instructions are provided on the [Provider Enrollment Risk Levels and Screening](#) page at in.gov/medicaid/providers. Provider specialties affected at enrollment and revalidation are identified on the [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#).

National Provider Identifier Requirements

The NPI is a 10-digit numeric identifier that is required for all healthcare providers (both individuals and organizations) that want to enroll in the IHCP. This standard, unique identifier is assigned by the National Plan and Provider Enumerator System (NPPES). Applying for an NPI is a separate process from IHCP enrollment.

Healthcare providers without an existing NPI must obtain one from the NPPES before submitting their application with the IHCP. To obtain an NPI, apply online at the [NPPES website](#) at nppes.cms.hhs.gov. For more information about NPI enumeration, see the [Enumeration Reports](#) page at cms.gov.

*Note: Some service providers, such as waiver providers and most transportation providers, are not considered healthcare providers. These providers, called **atypical providers**, are not required to have NPIs. When doing business with the IHCP, atypical providers use their IHCP Provider IDs (which all providers receive when they enroll in the IHCP) in place of an NPI.*

The IHCP requires healthcare providers to enroll or revalidate using the type of NPI that aligns with the organizational structure under which the provider will be doing business with the IHCP. There are two types of healthcare provider NPIs:

- **Type 1 (individual)** – A healthcare provider that is conducting business as an **individual** or as a **sole proprietor** must obtain a Type 1 NPI.
- **Type 2 (organizational)** – A healthcare provider that is conducting business as an **organization** or a distinct subpart of an organization, such as a group practice, a facility, or a corporation (including an **incorporated individual**), must also obtain a Type 2 NPI.

*Note: A healthcare provider rendering healthcare services as an individual practitioner and also conducting business as an incorporated entity, must obtain a Type 1 NPI as a practitioner and **also** a Type 2 NPI as a corporation or limited liability company (LLC).*

For providers enrolling or revalidating with the IHCP to bill for services (*billing provider* and *group provider* classifications), the organizational structure of the enrolling entity is determined by the information reported on the provider's IHCP enrollment application and on the Internal Revenue Service (IRS) W-9 form submitted with the application. Providers that do not bill the IHCP directly (*rendering provider* and *ordering, prescribing, or referring [OPR] provider* classifications) are not required to submit a W-9 form; the organizational structure associated with rendering providers is considered to be "individual" in all instances.

Alignment of the NPI type, organizational structure, legal name, and taxpayer identification number (tax ID) is required and will be verified as follows:

- An **individual healthcare practitioner** who is enrolling with the IHCP to render services but who **will not be billing the IHCP directly** for his or her services must enroll with the IHCP under the *rendering* provider classification (linked to one or more group providers) using the following:
 - His or her **Type 1 NPI**
 - His or her **personal name** as the legal name on the enrollment
 - His or her **Social Security number (SSN)** as the tax ID associated with the IHCP enrollment

The individual practitioner must provide proof of his or her proper licensure or certification with his or her IHCP rendering provider enrollment application.

Example: A nurse practitioner, is employed by AA Medical Group. The nurse practitioner's services are billed by and reimbursed to AA Medical Group. The nurse practitioner should be enrolled with the IHCP as a rendering provider under his or her own name, using his or her personal Type 1 NPI, and the enrollment should be linked to AA Medical Group (enrolled with the IHCP as a group provider using the business' Type 2 NPI).

- An **individual healthcare practitioner** who is enrolling to bill the IHCP directly for his or her services and is **conducting business with the IHCP as an individual or sole proprietor** (including a single-member LLC electing to do business as an individual, referred to as a *disregarded entity*), must enroll with the IHCP under the *billing* provider classification, using the following:
 - His or her **Type 1 NPI**
 - His or her **personal name** as the legal name on the enrollment (even if the individual operates under a doing business as [DBA] designation)
 - His or her **SSN or a federal employer identification number (EIN)** as the tax ID associated with the enrollment

The legal name, tax ID, and organizational structure on the W-9 must match the same information reported on the IHCP enrollment application. The individual practitioner must provide proof of his or her proper licensure or certification with the IHCP enrollment application. Billing providers do not bill the IHCP for services rendered by other providers and do not have providers enrolled with the IHCP as rendering providers linked to their enrollments.

Example: Dr. Smith is a sole proprietor, operating under the DBA Smith Medical Office. He bills and is reimbursed directly for services he personally renders. Dr. Smith enrolls with the IHCP as a billing provider under his personal name (listing Smith Medical Office as his DBA designation) using his personal Type 1 NPI.

- An **individual healthcare practitioner** who is enrolling to bill for his or her services and who is **conducting business with the IHCP as a business entity** (C Corporation, S Corporation, Partnership, or an LLC [including a single-member LLC electing to do business as a corporation]) must separately enroll both the business and him- or herself.

The **business** must be enrolled under the *group* provider classification using the following:

- The business entity's **Type 2 NPI**
- The business entity's **business name** as the legal name on the enrollment
- The business entity's EIN as the tax ID associated with the enrollment

In addition, the **practitioner** must enroll him- or herself under the *rendering* provider classification (linked to the group) using the following:

- His or her **Type 1 NPI**
- His or her **personal name** as the legal name on the enrollment
- His or her **SSN** as the tax ID associated with the enrollment

The business' legal name, tax ID, and organizational structure on its W-9 must match the same information reported on the IHCP enrollment application. The individual practitioner must provide proof of his or her proper licensure or certification with his or her IHCP rendering provider enrollment application.

Example: Dr. Jones is conducting business as a corporation, Jones Dental Services, LLC. She bills and is reimbursed for services she personally renders in the name of Jones Dental Services, LLC. Dr. Jones enrolls her business with the IHCP as a group provider under the name Jones Dental Services, LLC, using the business' Type 2 NPI. She also enrolls herself with the IHCP as a rendering provider under her own name, using her personal Type 1 NPI. Dr. Jones is linked as a rendering provider to the group Jones Dental Services. As a group provider, Jones Dental Services may have additional rendering providers linked to its IHCP enrollment.

- An **organization** that is enrolling to bill for services and that is **conducting business with the IHCP as a business entity** (including a C Corporation, S Corporation, LLC, Partnership, and Trust/Estate) must enroll under either the *billing* or *group* provider classification, using the following:
 - The business entity's **Type 2 NPI**
 - The business entity's **business name** as the legal name on the enrollment
 - The business entity's **EIN** as the tax ID associated with the enrollment

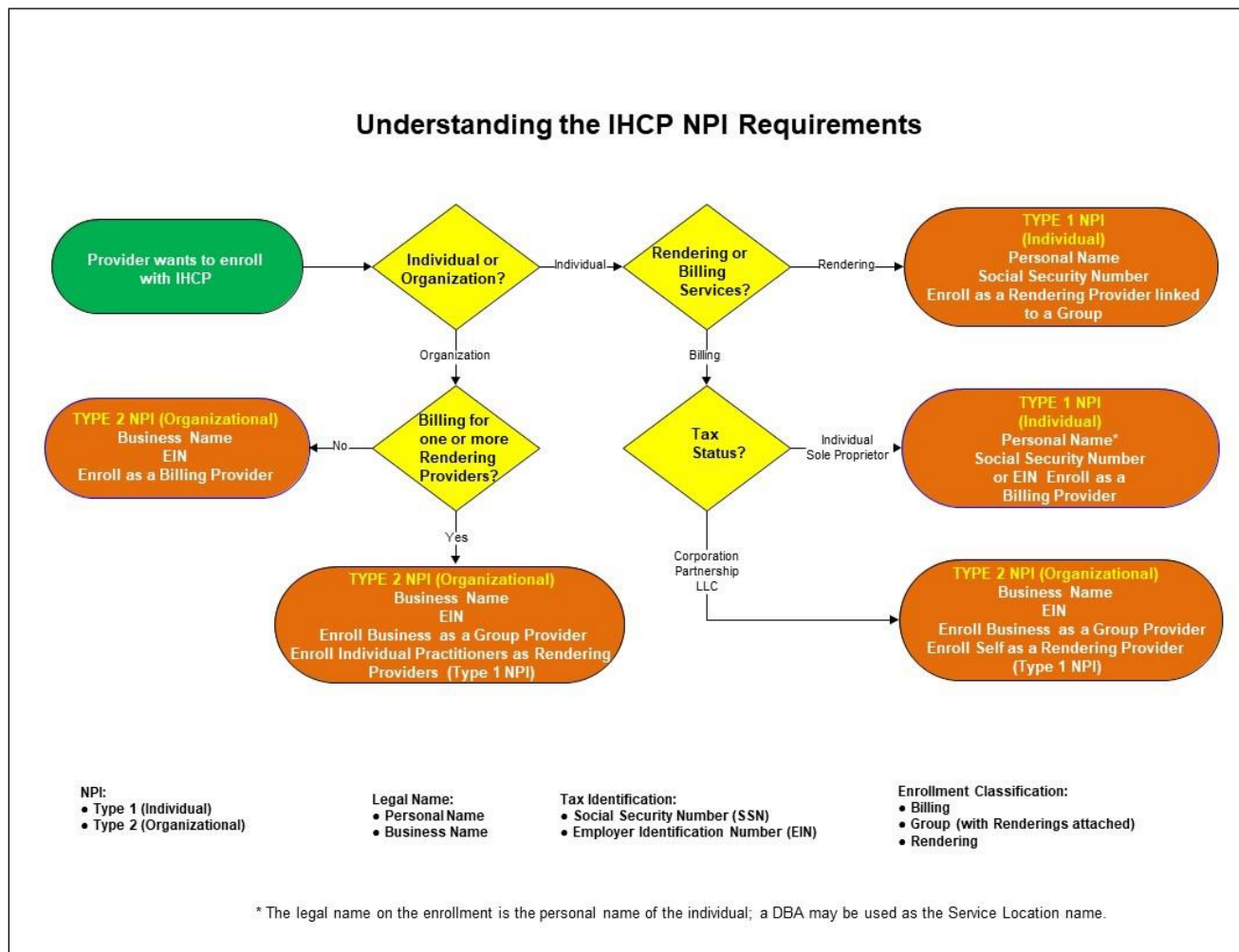
The legal name, tax ID, and organizational structure on the W-9 must match the same information reported on the IHCP enrollment application. An organization must enroll as a billing provider if it is not billing the IHCP for services rendered by individual rendering providers. An organization must enroll as a group provider if it is billing the IHCP for services rendered by one or more rendering providers. Any rendering providers linked to the organization's group enrollment must provide proof of proper licensure or certification with their IHCP rendering provider enrollment applications.

Example 1: ABC Medical Supply is a business entity conducting business as a C Corporation. The entity bills and is reimbursed for medical supplies in the name of ABC Medical Supply; there are no rendering providers (practitioners such as physicians, physician assistant, and so on) associated with the business. The business enrolls with the IHCP as a billing provider under the name ABC Medical Supply using the business' Type 2 NPI.

Example 2: Main Street Medical Group is a business entity conducting business as a partnership. The entity bills and is reimbursed for services rendered by employed physicians and nurse practitioners in the name of Main Street Medical Group. The business enrolls with the IHCP as a group provider using the business' Type 2 NPI. Each employed practitioner should be enrolled with the IHCP as a rendering provider under his or her personal name using his or her personal Type 1 NPI. The practitioners are linked as rendering providers to the group Main Street Medical Group.

Figure 1 presents a schematic illustration of the NPI and enrollment data reporting requirements. The NPI reporting requirements and related guidance do not apply to atypical provider types, including waiver and most transportation providers, which are not required to have an NPI and do not use an NPI for billing the IHCP.

Figure 1 – NPI Reporting Requirements Process



Provider Type and Specialty Requirements

This section identifies the enrollment requirements by provider type and specialty. For requirements associated with the OPR provider type, see the [Ordering, Prescribing, or Referring Providers \(Type 50\)](#) section.

A prospective provider can choose only one provider type per enrollment, but can choose any number of *specialties* under the selected provider type. If a prospective provider requires more than one provider type, another packet must be submitted and another provider number assigned.

Hospital (Type 01)

All hospitals are enrolled as **billing** providers and must be enrolled in Medicare to qualify for Medicaid enrollment. Four specialties are associated with provider type 01 – *Hospital*:

- 010 – *Acute Care*
- 011 – *Psychiatric Facility*
- 012 – *Rehabilitation*
- 013 – *Long Term Acute Care*

All in-state acute care, rehabilitation, and long-term acute care (LTAC) hospitals (specialties 010, 012, and 013) are certified by the Indiana State Department of Health (ISDH). The ISDH must forward documentation to DXC before IHCP enrollment can be finalized.

All in-state psychiatric hospitals (specialty 011) are licensed by the Division of Mental Health and Addiction (DMHA). Documentation of a license from the DMHA is required for IHCP enrollment.

Out-of-state acute care, psychiatric, and rehabilitation hospitals must submit a copy of their current license from the appropriate state. The rate-setting contractor furnishes DXC with rate information on medical education rates and costs-to-charge ratio information, if applicable.

All in-state LTAC hospitals (specialty 013) are first enrolled as licensed acute care hospitals. To change the provider specialty from 010 – *Acute Care* to 013 – *Long Term Acute Care*, the provider must be designated by the CMS as a long-term hospital for the Medicare program, or have an average inpatient length of stay greater than 25 days, based on the same criteria used by the Medicare program. Providers should contact Myers and Stauffer (the rate-setting contractor) for assistance in determining their qualifications as an LTAC hospital (see the [IHCP Quick Reference Guide](https://www.in.gov/medicaid/providers) at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers) for contact information). Out-of-state LTACs are not eligible for enrollment in the IHCP.

Note: Psychiatric hospitals with more than 16 beds may be enrolled in the IHCP as an institution of mental disease (IMD), following the definition in the Code of Federal Regulations 42 CFR 435.1010.

Ambulatory Surgical Center (Type 02)

All ambulatory surgical centers (ASCs) are enrolled as **billing** providers. The only specialty associated with provider type 02 – *Ambulatory Surgical Center* is specialty 020 – *Ambulatory Surgical Center (ASC)*.

The ISDH certifies in-state ASCs and must forward documentation to DXC before IHCP enrollment can be finalized. Out-of-state ASCs must submit a copy of their current license from the appropriate state.

Extended Care Facility (Type 03)

All extended care facilities are enrolled as **billing** providers. Five specialties are associated with provider type 03 – *Extended Care Facility*:

- 030 – *Nursing Facility*
- 031 – *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)*
- 032 – *Pediatric Nursing Facility*
- 033 – *Residential Care Facility*
- 034 – *Psychiatric Residential Treatment Facility (PRTF)*

All type 03 specialties require ISDH certification, and that documentation must be forwarded to DXC before enrollment is completed. Out-of-state extended care facilities are not eligible for enrollment in the IHCP.

The final rule published in the *Federal Register* modified 42 CFR 442.15 and eliminated the requirement for time-limited agreements for ICF/IID and residential care facility providers. As a result, provider specialties 031 and 033 no longer need to recertify each year by submitting a new provider agreement. These providers are still subject to enrollment revalidation requirements.

PRTFs (specialty 034) require the following:

- A Department of Child Services (DCS)-issued residential childcare license for a private, secure care facility
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) or Council on Accreditation (COA) accreditation
- An attestation letter for facility compliance

The [IHCP PRTF Attestation Letter/Maintenance Form](#) includes a model attestation letter for PRTFs. PRTFs are required to submit a new attestation letter to DXC annually.

Note: The model PRTF Provider Attestation Letter includes a State survey number, so that the ISDH and the FSSA can track facilities. The ISDH issues a State survey number after reviewing the PRTF Attestation Form. Because the State survey number is used for internal purposes, providers should disregard this field.

Rehabilitation Facility (Type 04)

Two specialties are associated with provider type 04 – *Rehabilitation Facility*:

- 040 – *Rehabilitation Facility*
- 041 – *Comprehensive Outpatient Rehabilitation Facility (CORF)*

All outpatient rehabilitation facilities with specialty 040 are enrolled as **billing** providers. All CORFs (specialty 041) are enrolled as **group** providers and must have a physician, a health service provider in psychology (HSPP), **and** a physical therapist linked to the group. CORFs must be enrolled in Medicare to qualify for Medicaid enrollment.

The ISDH certifies rehabilitation facilities and agencies, as well as CORFs. The ISDH must forward the documentation to DXC before the IHCP enrollment is completed. Out-of-state outpatient rehabilitation facilities (specialties 040 and 041) are not eligible for enrollment in the IHCP.

Home Health Agency (Type 05)

All home health agencies are enrolled as **billing** providers. The only specialty associated with the provider type 05 – *Home Health Agency* is specialty 050 – *Home Health Agency*. The ISDH is the sanctioning body that licenses home health agencies. The ISDH must forward the documentation to DXC before the enrollment can be finalized.

Out-of-state home health agencies are not eligible for enrollment in the IHCP.

Hospice (Type 06)

Hospice providers are enrolled as **billing** providers. A hospice provider must be enrolled and maintain enrollment in Medicare to be eligible to enroll in Medicaid. The only specialty associated with provider type 06 – *Hospice* is specialty 060 – *Hospice*.

Before hospice enrollment can be finalized, the following documentation is required:

- ISDH certification documentation forwarded to DXC
- A copy of the hospice license

Out-of-state hospice facilities are not eligible for enrollment in the IHCP. Some exceptions apply, as noted in the [Out-of-State Providers](#) module.

Clinic (Type 08)

Clinics are enrolled as **group** providers. The specialty of the rendering providers linked to the group is dependent on the specialty of the clinic. Provider type 08 – *Clinic* is used for freestanding clinics that have multiple provider types and specialties linked to the clinic.

Eight provider specialties are associated with provider type 08 – *Clinic*. The specific clinic provider specialties and the required documentation for each are as follows:

- 080 – *Federally Qualified Health Center (FQHC)* must have a nurse practitioner on staff and a physician linked to the group. Out-of-state FQHCs are not eligible for enrollment in the IHCP. Before enrollment is finalized, a CMS approval letter is required *for each location*. A usual and customary charge (UCC) rate for encounter code T1015 is also required before the provider may submit encounter claims. The rate-setting contractor sends DXC the UCC rate, and that rate is specific to the service location (practice site).
- 081 – *Rural Health Clinic (RHC)* must have a nurse practitioner on staff and a physician linked to the group. Out-of-state RHCs are not eligible for enrollment in the IHCP. Before the enrollment is finalized, a CMS approval letter is required *for each location*. A UCC rate for encounter code T1015 is required before the provider may submit encounter claims. The rate-setting contractor sends DXC the UCC rate, and that rate is specific to the service location (practice site).
- 082 – *Medical Clinic* has different rendering provider specialties – usually at different levels, such as nurses and doctors – linked to the clinic.
- 083 – *Family Planning Clinic* must have advanced registered nurse practitioners (APRNs) and/or physicians linked to the clinic.
- 084 – *Nurse Practitioner Clinic* must have one or more nurse practitioners linked to the clinic.
- 086 – *Dental Clinic* must have one or more dentists (provider type 27 – *Dentist* with any dental specialty other than 276 – *Mobile Dentist*) linked to the clinic. The term “dental” can only be used in the name of a corporation if all shareholders are licensed dentists.
- 087 – *Therapy Clinic* must have a minimum of two physicians plus one or more therapists (such as specialties 170 – *Physical Therapist*, 171 – *Occupational Therapist*, 173 – *Speech/Hearing Therapist*, or 615 – *Applied Behavior Analysis [ABA] Therapist*) linked to the clinic.
- 088 – *Birthing Center* must have certified nurse midwives or physicians linked to the clinic.

Advanced Practice Registered Nurse (Type 09)

For IHCP reimbursement, advanced practice registered nurses (APRNs) must be individually enrolled with the IHCP. APRNs may enroll as **billing** providers, **group** providers, or **rendering** providers linked to a group. Six specialties are associated with provider type 09 – *Advanced Practice Registered Nurse*:

- 090 – *Pediatric Nurse Practitioner*
- 091 – *Obstetric Nurse Practitioner*
- 092 – *Family Nurse Practitioner*
- 093 – *Nurse Practitioner (Other, such as clinical nurse specialist)*
- 094 – *Certified Registered Nurse Anesthetist (CRNA)*
- 095 – *Certified Nurse Midwife*

For enrollment with prescriptive authority, the enrollment application must include a current license issued by the appropriate state's licensing agency giving prescriptive authority. A copy of the nurse practitioner certification issued by an organization accredited for certifying nurse practitioners is also required for enrollment.

APRNs intending to be a primary medical provider (PMP) with a managed care program must choose an appropriate primary provider specialty. See the [Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment](#) section of this document for a list of the applicable provider specialties.

Physician Assistant (Type 10)

For IHCP reimbursement, physician assistants must be individually enrolled with the IHCP. Physician assistants may enroll as a **billing** provider or as a **rendering** provider under a group practice. The only specialty associated with provider type 10 – *Physician Assistant* is specialty 100 – *Physician Assistant*.

Physician assistants must hold a current professional license from the appropriate state's licensing agency to enroll with the IHCP.

Physician assistants may enroll in one or more MCE networks and serve as a PMP. See the [Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment](#) section.

Mental Health Provider (Type 11)

The classification under which a mental health provider enrolls depends on the provider's specialty. Specific requirements for each specialty associated with provider type 11 – *Mental Health Provider* are as follows:

- 110 – *Outpatient Mental Health Clinic* must be enrolled as a **group** provider with HSPPs, psychiatrists, or medical physicians linked to the group. A completed *IHCP Outpatient Mental Health Addendum* is required. Out-of-state outpatient mental health clinics are not eligible for enrollment in the IHCP.
- 111 – *Community Mental Health Center (CMHC)* must be enrolled as a **group** provider. Certification from the DMHA and a completed *IHCP Outpatient Mental Health Addendum* are required. Out-of-state CMHCs are not eligible for enrollment in the IHCP. CMHCs may provide primary care services to IHCP members; services must be provided by IHCP-enrolled providers authorized to provide primary healthcare.
- 114 – *Health Service Provider in Psychology (HSPP)* may be enrolled as a **billing** provider, a **group** provider, or a **rendering** provider linked to a group. A copy of the provider's current license, with the HSPP endorsement, from the appropriate state's licensing agency is required.

- 613 – *MRO Clubhouse* must be enrolled as a **rendering** provider that can render psychosocial rehabilitation services when linked to a DMHA-approved, IHCP-enrolled Medicaid Rehabilitation Option (MRO) group provider. Certification from the DMHA is required. Out-of-state MRO clubhouse providers are not eligible for enrollment in the IHCP.
- 615 – *Applied Behavior Analysis (ABA) Therapist* may be enrolled as a **billing** provider, a **group** provider with ABA therapists linked to the group, or a **rendering** provider linked to a group. ABA therapists enrolled as rendering providers can be linked to an outpatient mental health clinic, CMHC, HSPP, ABA therapist, medical clinic, therapy clinic, or any physician group practice. A valid professional license as a HSPP, as defined in *IC 25-33*, or a valid certification from the Behavior Analyst Certification Board (BACB) as a Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst-Doctoral (BCBA-D) is required.

Provider type 11 – *Mental Health Provider* also includes the following specialties, associated with the 1915(i) Home and Community-Based Services (HCBS) programs under the Indiana State Plan and administered by the DMHA:

- 115 – *Adult Mental Health and Habilitation (AMHH)* may be enrolled as a **billing** provider, a **group** provider, or a **rendering** provider linked to a group. DMHA adult provider certification is required. Out-of-state providers are not eligible.
- 611 – *Child Mental Health Wraparound (CMHW)* may be enrolled as a **billing** provider, a **group** provider, or a **rendering** provider linked to a group. Certification from the DMHA is required. Out-of-state providers are not eligible.
- 612 – *Behavioral and Primary Healthcare Coordination (BPHC)* is a specialty that is only added to an enrolled CMHC with certification by DMHA. Out-of-state providers are not eligible.

School Corporation (Type 12)

School corporations and charter schools are enrolled as **billing** providers. The only specialty associated with provider type 12 – *School Corporation* is specialty 120 – *School Corporation*. The school corporation or charter school must be listed on the approved Indiana Department of Education's school corporation or charter school listings. Cooperatives (co-ops) within school corporation districts are not enrolled in the IHCP; only the school corporation is enrolled. Out-of-state school corporations are not eligible for enrollment in the IHCP.

Public Health Agency (Type 13)

Public health agencies are enrolled as **billing** providers or **group** providers. The only specialty associated with provider type 13 – *Public Health Agency* is specialty 130 – *County Health Department*. Out-of-state public health agencies are not eligible for enrollment in the IHCP.

Podiatrist (Type 14)

Podiatrists may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group. Individual providers must submit a copy of their current and active license from the appropriate state's licensing agency. The only specialty associated with provider type 14 – *Podiatrist* is specialty 140 – *Podiatrist*.

Chiropractor (Type 15)

Chiropractors may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group. Individual providers must submit a copy of their current and active license from the appropriate state's licensing agency. The only specialty associated with provider type 15 – *Chiropractor* is specialty 150 – *Chiropractor*.

Therapist (Type 17)

Therapists may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group. A copy of a current and active license from the appropriate state's licensing agency is required. Three specialties are associated with provider type 17 – *Therapist*:

- 170 – *Physical Therapist*
- 171 – *Occupational Therapist*
- 173 – *Speech/Hearing Therapist*

Optometrist (Type 18)

Optometrists may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group. In accordance with IC 25-1-9-5, optometry groups must be owned by optometrists. A copy of a current and active license from the appropriate state's licensing agency is required. The only specialty associated with provider type 18 – *Optometrist* is specialty 180 – *Optometrist*.

Optician (Type 19)

Opticians are enrolled as **billing** providers or as **rendering** providers linked to an optometrist group. Opticians cannot enroll as a group provider. The only specialty associated with provider type 19 – *Optician* is specialty 190 – *Optician*.

Audiologist (Type 20)

Audiologists may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group. A copy of a current and active license from the appropriate state's licensing agency is required. The only specialty associated with provider type 20 – *Audiologist* is specialty 200 – *Audiologist*.

Audiologists who are also hearing aid dealers do not need to enroll separately as a hearing aid dealer.

Hearing Aid Dealer (Type 22)

Hearing aid dealers can be enrolled as **billing** providers only. Hearing aid dealers cannot enroll as a group nor as a rendering provider linked to a group. A copy of a current and active hearing aid dealer license from the appropriate state's licensing agency is required. The only specialty associated with provider type 22 – *Hearing aid dealer* is specialty 220 – *Hearing aid dealer*.

Pharmacy (Type 24)

Pharmacies are enrolled as **billing** providers only. Provider type 24 – *Pharmacy* must enroll with a primary specialty of 240 – *Pharmacy*. Pharmacy providers can add the provider specialties 250 – *DME/Medical Supply Dealer* and 251 – *HME/Home Medical Equipment* when applicable. One IHCP Provider ID is assigned to the provider for all the specialties. When a pharmacy chain is enrolled, each store receives an individual Provider ID, which can include one or all of the specialties.

A copy of the current and active pharmacy license (or permit) from the applicable state's licensing agency must be submitted for enrollment in the IHCP. To add the HME specialty to a pharmacy provider's enrollment, a copy of the HME license from the Indiana State Board of Pharmacy is also required.

Out-of-state pharmacy providers that deliver drugs or devices to Indiana patients via the U.S. Postal Service or other delivery services, such as FedEx or DHL, are required to have an Indiana nonresident pharmacy license as well as a license issued by their home state.

Durable Medical Equipment (Type 25)

DME providers can be enrolled as **billing** providers only. Stand-alone DME providers are enrolled under provider type 25 – *Durable Medical Equipment/Medical Supply Dealer* and are assigned specialty 250 – *DME/Medical Supply Dealer*. DME providers can add specialty 251 – *HME/Home Medical Equipment* to their enrollment when applicable. To add the HME specialty to a DME provider's enrollment, a copy of the HME license from the Indiana State Board of Pharmacy must be submitted with the enrollment.

For out-of-state enrollment from a state that licenses DME providers, a license from the state's licensing agency is required. Out-of-state DME providers require prior authorization for services unless the provider has a service location (practice site) in Indiana.

Home Medical Equipment (Type 25)

HME providers can be enrolled as **billing** providers only. Stand-alone HME providers are enrolled under provider type 25 – *Durable Medical Equipment/Medical Supply Dealer* and are assigned specialty 251 – *HME/Home Medical Equipment*. HME providers can add specialty 250 – *DME/Medical Supply Dealer* to their enrollment when applicable.

All HME providers (including out-of-state providers) that render services to Indiana clients must have an HME license from the Indiana State Board of Pharmacy and must present a copy of the license with their enrollment. Out-of-state HME providers require prior authorization for services unless the provider has a service location (practice site) in Indiana.

Transportation (Type 26)

Transportation providers can be enrolled as **billing** providers only and must be recertified annually or as required by permits, certificates, and liability insurance coverage periods. A provider seeking to enroll transportation services must make transportation services available to the general public and demonstrate that its primary business function is the provision of transportation services. This requirement does not apply to transportation providers that provide only ambulance, family member, or school corporation transportation services.

Note: Individualized Education Program (IEP) transportation services provided in accordance with 405 IAC 5-30-11 must conform to the requirements set out in IC 20-27 and are exempt from the transportation provider agreement requirements.

Seven specialties are associated with transportation providers. The following list includes specific IHCP enrollment requirements for each specialty associated with provider type 26 – *Transportation*:

- **260 – Ambulance**

Ambulance providers must submit a copy of their emergency medical services (EMS) commission certificate for enrollment and recertification in the IHCP, based on certificate end date.

- **261 – Air Ambulance**

Air ambulance providers must submit a copy of their EMS commission certificate for enrollment and annual recertification in the IHCP.

- **262 – Bus**

Bus providers must submit a copy of their Motor Carriers Services (MCS) certificate issued by the Indiana Department of Revenue for enrollment and annual recertification in the IHCP.

- 263 – Taxi

Taxi providers must submit a document showing operating authority from a local governing body (city taxi or livery license); a copy of appropriate and valid driver's licenses for all drivers; and proof of livery insurance indicated by local ordinances or, if unspecified by local ordinance, a minimum of \$25,000/\$50,000 of public livery insurance covering all vehicles used in the business.

Taxi providers cannot transport outside the jurisdiction designated by their city taxi license. To transport outside the jurisdiction, the taxi provider must be enrolled as a common carrier, provider specialties 264 and 265. If a taxi transports across county borders, the Indiana Department of Revenue's Motor Carrier Services Division must certify as a common carrier.

- 264 – Common Carrier (Ambulatory) and 265 – Common Carrier (Nonambulatory)

Common carrier providers are categorized as for-profit and not-for-profit businesses. Each category has specific certification and supporting documentation requirements:

- For-profit common carriers must submit a copy of their MCS certificate from the Indiana Department of Revenue, proof of insurance coverage, and appropriate and valid driver's licenses for all drivers.
- Not-for-profit common carriers must submit a copy of their not-for-profit status from the IRS, a copy of appropriate and valid driver's licenses for all drivers, and proof of insurance (the requirement is \$500,000 combined single limit commercial automobile liability insurance).

*Note: The IHCP provides reimbursement for transportation of ambulatory members (individuals who are able to walk or can transfer from a wheelchair without assistance) to or from an IHCP-covered service. Commercial or common ambulatory service (CAS) transportation may be provided in any type of vehicle. The IHCP reimburses for nonambulatory services (NAS) or wheelchair services when a member must travel **in a wheelchair** to or from an IHCP-covered service.*

- 266 – Family Member

The IHCP allows a family member or close associate of an IHCP member to officially enroll as a driver, so the driver's mileage can be reimbursed. This provider type specialty is appropriate for members who must make frequent trips for medical services, and who have a person willing and able to transport them, but doing so presents a financial burden.

When a family member is enrolled as a transportation provider, that individual may provide services only to the designated member, and those services are subject to prior authorization.

To enroll as a family member transportation provider, the family member or associate must submit the following documents:

- [IHCP Family Member/Associate Transportation Provider Enrollment and Profile Maintenance Packet](#), completed and signed by the enrolling driver
- [Medicaid Family Member or Associate Transportation Services Form](#), completed and signed by the IHCP member
- Copy of driver's license
- Copy of current auto insurance for the vehicle being used (must be minimum state required limits)
- Copy of current auto registration for the vehicle being used
- A W-9 tax form

Out-of-state family member transportation providers are not eligible for enrollment in the IHCP.

Note: Common carrier and taxi providers that transport their family members must have a separate enrollment as a family member transportation provider to be reimbursed.

Surety Bond Requirements

The IHCP requires a surety bond from entities applying to enroll as provider type 26 – *Transportation* with any of the following provider specialties:

- 263 – *Taxi*
- 264 – *Common Carrier (Ambulatory)*
- 265 – *Common Carrier (Nonambulatory)*

The surety bond must be in the amount of at least \$50,000 and must last a minimum of 3 years.

The following are exceptions to the surety bond requirement:

- Not-for-profit status – a 501(c)(3) organization only
- Owned or controlled by a person that is licensed or certified by the IPLA
- Owned or controlled by a pharmacy with a permit issued by the Indiana Board of Pharmacy
- Owned or controlled by a hospital licensed by the ISDH
- Granted a waiver of the requirement at the discretion of the Secretary of FSSA:
 - If transportation services are to be provided in a federal or state designated underserved area
 - If it has been determined the provider does not pose a significant risk of submitting fraudulent or false Medicaid claims

Providers seeking a waiver of the surety bond requirement must submit a written request with their online Portal application or paper enrollment packet. The letter must specify why the request is being made and how the enrolling provider believes they qualify for the waiver. The final decision whether to waive the requirement will be made by the FSSA.

Note: If a waiver is requested, the provider's application will not be processed until a decision is made to grant or deny the waiver.

If the waiver is not granted, the provider has 30 days from the date on the notice of rejection to submit the required bond.

The required surety bond can be obtained by contacting a licensed insurance broker who will find a company to underwrite the bond. It is important that the broker be given the specific surety bond requirements to ensure that the bond is compliant with the new regulation. The [Indiana Medicaid Surety Bond Requirements](#) document at in.gov/medicaid/providers outlines the requirements and can be copied for reference by the insurance broker. The document includes a link to Indiana's Medicaid Transportation Provider Surety Bond form (State Form 55382).

Dentist (Type 27)

Dentists may be enrolled in the IHCP as **billing** providers, **group** providers, or **rendering** providers linked to a group. Dental practices must be owned by licensed dentists. Indiana law prohibits a non-dentist owner in any dental practice. Provider type 27 – *Dentist* includes the following specialties, all of which require submission of a copy of a current license issued by the appropriate state's licensing agency:

- 270 – *Endodontist*
- 271 – *General Dentistry Practitioner*
- 272 – *Oral Surgeon*
- 273 – *Orthodontist*

- 274 – *Pediatric Dentist*
- 275 – *Periodontist*
- 276 – *Mobile Dental Van*
- 277 – *Prosthesis*

Provider specialty 276 – *Mobile Dental Van* must be enrolled as a group with members and must submit a copy of their current Mobile Dental License issued by the IPLA. This specialty is not eligible for out-of-state enrollment.

Laboratory (Type 28)

Four specialties are associated with provider type 28 – *Laboratory*:

- 280 – *Independent Lab*
- 281 – *Mobile Lab*
- 282 – *Independent Diagnostic Testing Facility (IDTF)*
- 283 – *Mobile Independent Diagnostic Testing Facility (IDTF)*

The provider specialties can enroll as follows:

- 280 and 281 – **Billing** provider only
- 282 – **Group** provider only
- 283 – Either a **billing** provider or a **group** provider

A Clinical Laboratory Improvement Amendment (CLIA) certificate is required for independent labs and mobile labs for the location where services are rendered. IDTFs and mobile IDTFs do not require a CLIA certificate.

Radiology (Type 29)

Radiology clinics can be enrolled as **billing** providers or **group** providers. A radiology group's rendering providers are enrolled with provider type 31 – *Physician* with provider specialty 341 – *Radiologist*.

Two specialties are associated with provider type 29 – *Radiology*:

- 290 – *Freestanding X-Ray Clinic*
- 291 – *Mobile X-Ray Clinic*

Radiology providers are required to submit a copy of their registration certificate, ISDH Notice of Compliance, and operator certificates for all employee operators except positron emission tomography (PET) or computer tomography (CT) scanner operators.

Note: PET and magnetic resonance imaging (MRI) services do not require certification or a Notice of Compliance.

Out-of-state mobile radiology providers (specialty 291) performing services in Indiana must be certified in Indiana and possess a Notice of Compliance in Indiana. All operators must be certified in the state of Indiana.

End-Stage Renal Disease Clinic (Type 30)

End-stage renal disease (ESRD) clinics must be enrolled as **billing** providers. They cannot be enrolled as group providers. The only specialty associated with provider Type 30 – *End-Stage Renal Disease (ESRD) Clinic* is specialty 300 – *Free-Standing Renal Dialysis Clinic*. Out-of-state ESRD clinics are not eligible for enrollment in the IHCP.

The ISDH sends certification information to DXC. ESRD clinics are required to have a valid CLIA certificate on file with the IHCP. This CLIA certificate can be for the lab that the ESRD clinic provider contracts with to perform lab services. It is the provider's responsibility to update CLIA certifications if there are changes to the CLIA certification level or if the CLIA number changes. The CMS regularly notifies DXC of updates to the end date for the CLIA number on file, but providers must still report as an update any change to the CLIA number on file.

Physician (Type 31)

Physicians may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group. A copy of a current physician's license issued by the appropriate state for the physical location where services are rendered must be submitted for enrollment in the IHCP. Physician groups are required to enroll each service location (practice site) they operate and submit rendering provider documents for linkage to the service locations (practice sites).

The following specialties are associated with provider type 31 – *Physician*:

- 310 – *Allergist*
- 311 – *Anesthesiologist*
- 312 – *Cardiologist*
- 313 – *Cardiovascular Surgeon*
- 314 – *Dermatologist*
- 315 – *Emergency Medicine Practitioner*
- 316 – *Family Practitioner*
- 317 – *Gastroenterologist*
- 318 – *General Practitioner*
- 319 – *General Surgeon*
- 320 – *Geriatric Practitioner*
- 321 – *Hand Surgeon*
- 323 – *Neonatologist*
- 324 – *Nephrologist*
- 325 – *Neurological Surgeon*
- 326 – *Neurologist*
- 327 – *Nuclear Medicine Practitioner*
- 328 – *Obstetrician/Gynecologist*
- 329 – *Oncologist*
- 330 – *Ophthalmologist*

- 331 – *Orthopedic Surgeon*
- 332 – *Otologist/Laryngologist/Rhinologist*
- 333 – *Pathologist*
- 334 – *Pediatric Surgeon*
- 336 – *Physical Medicine and Rehabilitation Practitioner*
- 337 – *Plastic Surgeon*
- 338 – *Proctologist*
- 339 – *Psychiatrist*
- 340 – *Pulmonary Disease Specialist*
- 341 – *Radiologist*
- 342 – *Thoracic Surgeon*
- 343 – *Urologist*
- 344 – *General Internist*
- 345 – *General Pediatrician*
- 346 – *Dispensing Physician*

Physicians intending to be a primary medical provider (PMP) with a managed care program must choose an appropriate primary provider specialty. See the [Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment](#) section of this document for a list of the applicable provider specialties.

Locum tenens and *substitute physicians* are physicians that fill in for a member's regular physician. A *locum tenens* or substitute physician must be from the same discipline as the regular physician. A *substitute physician* is a physician who is asked to see a member in a reciprocal arrangement when the regular physician is unavailable to see the member. Substitute physicians are required to be enrolled in the IHCP. The *locum tenens* arrangement is made when the regular physician must leave his or her practice due to illness, vacation, or medical education opportunity and does not want to leave his or her patients without service during the period. The *locum tenens* physician cannot be a member of the group in which the regular physician is a member. The *locum tenens* physician must meet all requirements to practice in Indiana; however, the *locum tenens* physician is not required to be an enrolled IHCP provider. For more information about billing for *locum tenens* and substitute physicians, see the [Substitute Physicians and Locum Tenens](#) section of this document.

Home and Community-Based Services 1915(c) Waiver (Type 32)

Becoming a waiver provider begins with the FSSA certification process and is finalized with the IHCP provider enrollment process.

FSSA Certification

Before submitting an IHCP enrollment application, the provider must first be certified by either the FSSA Division of Aging (DA) or the FSSA Division of Developmental and Rehabilitative Services (DDRS), depending on the Home and Community-Based Services (HCBS) waiver services being provided.

Prospective waiver providers must contact the appropriate FSSA HCBS Waiver Unit to request certification:

- For the intermediate care facility for individuals with intellectual disabilities (ICF/IID) level-of-care waivers (Community Integration and Habilitation [CIH] Waiver and Family Supports Waiver [FSW]), contact:

MS18

Director of Provider Services

DDRS – Division of Disabilities and Rehabilitative Services

402 W. Washington St., Room W453

Indianapolis, IN 46204-2243

Email: BDDSPROVIDER@fssa.IN.gov

- For the nursing facility level-of-care waivers (Aged and Disabled [A&D] and Traumatic Brain Injury [TBI] Waivers) and the Money Follows the Person (MFP) demonstration grant, contact:

MS21

Waiver/Provider Analyst

Family and Social Services Administration

Indiana Health Coverage Programs (IHCP)

Division of Aging Home and Community-Based Services Waivers

P.O. Box 7083

402 W. Washington St., Room W454

Indianapolis, IN 46027-7083

Email: DAPROVIDERAPP@fssa.in.gov

IHCP Enrollment

Provider type 32 – *Waiver* may be enrolled as **billing** providers, **group** providers, or **rendering** providers linked to a group.

Seven specialties are associated with the waiver provider type. Each specialty has multiple secondary specialties. The *Waiver Certification Form*, issued by the waiver agency, lists the specialties and secondary specialties for which the provider has been approved.

The specialties are associated with the waiver provider type 32.

- 350 – *Aged and Disabled (A&D) Waiver*
- 356 – *Traumatic Brain Injury (TBI) Waiver*
- 359 – *Community Integration and Habilitation Waiver*
- 360 – *Family Supports Waiver*
- 363 – *Money Follows the Person (MFP) Demonstration Grant*

For a list of the secondary specialties, see the [IHCP Provider Enrollment Type and Specialty Matrix](#).

MRT Copy Center (Type 34)

Entities that provide only medical record copying and provision for the Medical Review Team (MRT) program are enrolled as **billing** providers under provider type 34 – *MRT Copy Center*. The only specialty associated with this provider type is specialty 366 – *MRT Copy Center*. See the [Provider Enrollment in the Medical Review Team Program](#) section for more enrollment information.

Addiction Services (Type 35)

The following specialties are associated with provider type 35 – *Addiction Services*:

- 835 – *Opioid Treatment Program (OTP)*
- 836 – *Substance Use Disorder (SUD) Residential Addiction Treatment Facility*

Opioid Treatment Programs

Note: In accordance with Senate Enrolled Act (SEA) 297 (2016), Indiana Code IC 12-23-18-0.5 mandates that OTPs shall not operate in the state of Indiana unless they are enrolled with the IHCP. OTPs may enroll with the IHCP as billing providers (as described in this section) or as ordering, prescribing, or referring (OPR) providers (see the [Opioid Treatment Programs Enrolled as OPRs](#) section).

OTPs may be enrolled under the provider type and specialty that best identifies their practice. However, OTPs wanting to bill the IHCP for the administration of methadone and other related services exclusive to OTPs must be enrolled as a **billing** provider under provider type 35, specialty 835.

*Note: A provider already enrolled with the IHCP as provider type 11 – Mental Health Provider or type 08 – Clinic is required to **submit a separate application to also enroll as provider type 35 – Addiction Services**.*

All OTP providers enrolling with the IHCP under the addiction services/OTP provider type and specialty or as an OPR will be required to have a Drug Enforcement Administration (DEA) license, as well as certification from the State's DMHA. See the [IHCP Provider Enrollment Type and Specialty Matrix](#) for additional documentation requirements. Out-of-state OTPs are not eligible for enrollment in the IHCP.

Substance Use Disorder Residential Addiction Treatment Facilities

Beginning March 1, 2018, facilities can enroll in the IHCP as SUD residential addiction treatment facilities (provider type 35, specialty 836). Facilities that meet the DMHA requirements and are currently enrolled under another provider type and specialty (such as psychiatric hospitals – provider type 01, specialty 011) can be reimbursed for residential stays for substance use treatment on a per diem basis for an interim period of time – only for dates of service through June 30, 2018. For dates of service on or after July 1, 2018, reimbursement for SUD residential treatment will **only** be made to facilities that are enrolled as provider type 35 with specialty 836. Any facility enrolled with the IHCP under a different provider type and specialty will be required to submit a separate application to also enroll as provider type 35, specialty 836, to continue receiving reimbursement for these services. Facilities with the provider type 35 and specialty 836 are enrolled as **billing** providers.

To enroll as an SUD residential addiction treatment facility, a facility must meet the following requirements and submit proof of both:

- DMHA certification as a sub-acute facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services
- Department of Child Services (DCS) licensing as a child care institution or private secure care institution with a DMHA Addiction Services Provider, Regular Certification that includes ASAM designation of offering either Level 3.1 or Level 3.5 residential services

Information about the ASAM designation process can be found on the [American Society of Addiction Medicine \(ASAM\) Designation](#) page at in.gov/fssa/dmha. Providers that wish to be reimbursed by IHCP for SUD residential services must complete the ASAM designation process.

A provider enrolled as an SUD residential addiction treatment facility (provider type 35, specialty 836) is limited to billing only the following procedure codes under that enrollment:

- H2034 U1 or U2 – *Low-Intensity Residential Treatment (child or adult)*
- H0010 U1 or U2 – *High-Intensity Residential Treatment (child or adult)*

SUD residential addiction treatment providers rendering services other than those included in the per diem payment associated with these procedure codes must bill for those additional services using another, appropriate IHCP-enrolled provider type and specialty. Services included in the per diem payment will not be reimbursed separately for a member for the same date of service as the per diem payment is reimbursed.

Genetic Counselor (Type 36)

Professionally licensed genetic counselors can enroll in the IHCP as provider type 36 – *Genetic Counselor* with specialty 800 – *Genetic Counselor*. To enroll with the IHCP as provider type 36, genetic counselors must hold a valid professional license as a genetic counselor, as defined in *IC 25-17.3*. Although licensed physicians and nurses are not required to be licensed as a genetic counselor to provide genetic counseling within their scope of practice, *IC 25-17.3-4-4* stipulates that providers cannot use the title “genetic counselor” unless licensed as such.

Genetic counselors may enroll under provider type 36 as a **billing** provider, a **group** provider, or a **rendering** provider under a group practice. Genetic counselor group practices can have only providers with specialty 800 – *Genetic Counselor* linked to the group as rendering providers. Genetic counselors enrolled as rendering providers can be linked with any of the following types of group practices:

- Type 08 – *Clinic* with the following specialty codes:
 - 082 – Medical Clinic
 - 083 – Family Planning Clinic
 - 084 – Nurse Practitioner Clinic
 - 087 – Therapy Clinic
- Type 09 – *Advanced Practice Registered Nurse* with the following specialty codes:
 - 090 – Pediatric Nurse Practitioner
 - 091 – Obstetric Nurse Practitioner
 - 092 – Family Nurse Practitioner
 - 093 – Nurse Practitioner (other, such as clinical nurse specialist)
 - 095 – Certified Nurse Midwife
- Type 11 – *Mental Health Provider* with the following specialty codes:
 - 110 – Outpatient Mental Health Clinic
 - 111 – Community Mental Health Center (CMHC)
 - 114 – Health Service Provider in Psychology (HSPP)
- Type 31 – *Physician*
 - All specialties
- Type 36 – *Genetic Counselor*
 - 800 – Genetic Counselor

Genetic counselor (type 36) providers – whether enrolled as a billing provider, group provider, or rendering provider under any type of group practice – are limited to providing only genetic counseling services and to billing only the following procedure codes:

- 96040 – *Medical genetic patient or family counseling services each 30 minutes*
- S9981 SE – *Medical records copying fee, administrative*

Other provider types enrolled with the IHCP that have genetic counseling within their scope of practice should bill for these services following standard billing guidance.

Community Health Workers

Community health workers (CHWs) do not enroll as providers with the IHCP. Rather, CHWs are required to be employed by an IHCP-enrolled billing provider and to deliver services under the supervision of one of the following IHCP-enrolled provider types:

- Physician
- Health Services Provider in Psychology (HSPP)
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA)
- Podiatrist
- Chiropractor

The billing provider must maintain documentation of CHW certification for the individual providing the CHW services. The IHCP will recognize certification from the following entities to demonstrate that the core competencies of a CHW have been met:

- Mental Health America of Northeast Indiana (MANI)
- Affiliated Service Providers of Indiana (ASPIN)
- HealthVisions Midwest

Enrollment Effective Dates

The normal effective date of IHCP provider enrollment is the date the Provider Enrollment Unit receives the enrollment application.

Retroactive Enrollment

A retroactive enrollment date of no more than 1 year may be considered for approval by the FSSA in the following cases:

- A provider has proof of service rendered to an IHCP member within 12 months prior to the application received date, and both of the following apply:
 - All screening activities can support that the provider was compliant as of the requested date.
 - The provider is enrolled with Medicare on the requested date.
- An out-of-state provider provided services for an IHCP member in need of care while traveling.

A rendering provider's effective date cannot be earlier than the effective date of the group to which the provider is linked.

Requests to backdate enrollment for other reasons will be reviewed for approval by the FSSA.

Note: The provider's certification or license must be active for the entire retroactive period being requested. For providers that are surveyed by the ISDH and require certification for enrollment (Type 01 – Hospital, Type 02 – ASC, Type 03 – LTC, Type 05 – Home Health, and Type 06 – Hospice), the effective program start date cannot be earlier than the survey date or effective date provided by ISDH.

Claim Filing

Providers can bill for covered services rendered to IHCP members starting on their enrollment effective date, subject to the claim filing limit of 180 days. For a claim to be considered for reimbursement, the dates of service must be on or after the enrollment start dates. For group and clinic provider entities, the dates of service being billed must be on or after the rendering practitioner linkage effective date.

If the service was rendered more than 180 days ago, the provider must submit a paper claim and the appropriate documentation to request a filing limit waiver. See the [Claim Submission and Processing](#) module for details on how to submit a claim with filing limit waiver documentation.

Note: For claims with dates of service before January 1, 2019, the claim filing limit is 1 year.

Prior Authorization

Prior authorization (PA) for medically necessary covered services, if applicable, can be requested for a period beginning from the effective date of the provider's enrollment. If PA is required for a covered service that had already occurred, it can be requested retroactively up to 1 year from the date the provider was enrolled. The provider must indicate on the PA request that the reason for the untimely request is "retroactive enrollment." Authorization is determined solely on the basis of medical necessity. See the [Prior Authorization](#) module for details about PA.

Section 3: Provider Enrollment Steps

Before applying to enroll with the Indiana Health Coverage Programs (IHCP), providers should visit the [IHCP Provider Enrollment Transactions](#) page at in.gov/medicaid/providers. Providers can view the [IHCP Provider Enrollment Type and Specialty Matrix](#) to determine the correct provider type and specialty enrollment requirements for their business entity.

For instructions on enrolling as an OPR provider, see [Section 5: Ordering, Prescribing, or Referring Providers \(Type 50\)](#).

Note: Providers are strongly encouraged to use the IHCP [Provider Healthcare Portal](#) (Portal), accessible from the home page at in.gov/medicaid/providers, for provider enrollment applications, revalidations, and profile updates whenever possible, as electronic transactions can be processed more efficiently than paper submissions. Not only is the Portal designed to reduce errors in initial submissions, but it also provides a tracking number that is helpful in tracking subsequent submissions if follow-up is needed for missing information or documents.

However, providers unable to use the Portal do have the option to submit paper enrollment applications.

Online Enrollment Using the Provider Healthcare Portal

The Portal allows providers to enroll in the IHCP based on provider type and provider classification (group, billing, rendering, or OPR).

Prospective IHCP providers are able to submit an enrollment application, resume an enrollment application, and check their enrollment status on the Portal. To begin the enrollment process online, follow these steps:

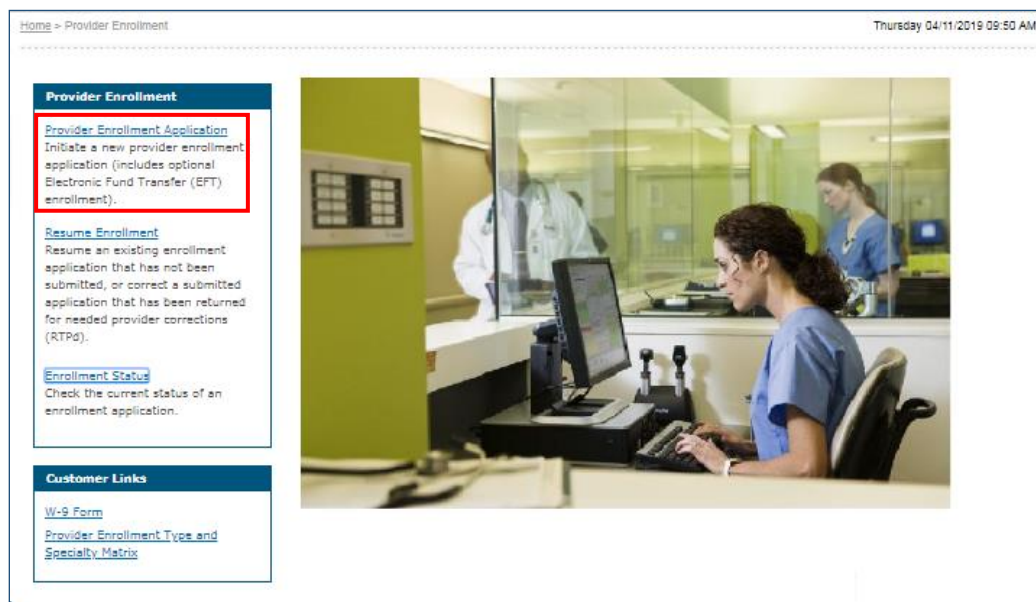
1. Go to the [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers.
2. Click the Provider Enrollment link (see [Figure 2](#)).

Figure 2 – Provider Enrollment Option



3. Click the **Provider Enrollment Application** link (see Figure 3).

Figure 3 – Provider Enrollment Application Link



4. Read the introductory information on the *Welcome* page and then click **Continue** (see Figure 4).

Figure 4 – Welcome Page

5. In the Initial Enrollment Information section on the Request Information page (see Figure 5):
- Select the appropriate provider classification (group, billing, rendering, or OPR) from the **Provider Classification** drop-down box. (See the [Provider Classifications](#) section for more information.)
 - Select the appropriate provider type from the **Provider Type** drop-down box. (See the [Provider Type and Specialty Requirements](#) section for more information.)
 - Select New Enrollment from the **Enrollment Request Type** drop-down box (unless the enrollment is a change of ownership or to add a service location for a currently enrolled provider).

Figure 5 – Request Information Page

6. Follow instructions to complete the remaining sections of the application.

After submitting an enrollment application on the Portal, providers receive a tracking number. To check on the status of an enrollment, the provider can complete these steps:

1. Go to the [Provider Healthcare Portal](#), accessible from the home page at [in.gov/medicaid/providers](#).
2. Click the Provider Enrollment link.
3. Click the Provider Enrollment Status link.
4. In the *Provider Enrollment – Status* panel (see Figure 6), enter the tracking number for the application and the federal employer identification number (EIN) or Social Security number (SSN) for the provider.

Figure 6 – Check Enrollment Status

After they are enrolled, providers can register to use the Portal to update their enrollment information, complete revalidation tasks, and disenroll from the IHCP, in addition to submitting claims, requesting prior authorization (PA), and performing other day-to-day transactions. For additional help using the Portal, online web-based training for the Portal is available on the [Provider Healthcare Portal Training](#) page at [in.gov/medicaid/providers](#).

IHCP Provider Packet for Paper Enrollment Submission

To enroll by mail using a printed IHCP provider packet, go to the [Complete an IHCP Provider Enrollment Application](#) page at [in.gov/medicaid/providers](#) and select the appropriate provider type to access the corresponding enrollment packet.

Enrollment packets vary based on provider type (see the [IHCP Provider Enrollment Type and Specialty Matrix](#)) and provider classification (group, billing, rendering, or OPR). For example, a hospital application is different from a transportation provider's application, and a billing provider application is different from a rendering provider application.

Current and appropriate provider enrollment and profile maintenance forms are necessary to facilitate accurate enrollment and profile updates. Use the most current version of the forms, and read the instructions carefully before completing and submitting the form. (See the [Provider Profile Maintenance](#) section for information on updating existing information for an enrolled provider.)

Note: Providers should always verify that the form is the most current version available. Previous versions of provider enrollment forms are not acceptable and are returned with a request for the correct version.

All provider enrollment and profile maintenance forms are available as Adobe PDF files and have a “Save As” function. Providers may complete the forms electronically before printing them, or print them out and complete them by hand. The following guidelines apply for paper enrollment submissions:

- The use of liquid correction fluid or correction tape is not acceptable in any area of the enrollment or profile maintenance form.
- Appropriate signatures are required.
- All signatures must be in blue or black ink and cannot be copies or any other facsimile.
- Signatures must be legible.

*Note: An enrollment is not processed without a completed enrollment application including a signed signature page and a signed provider agreement. For rendering provider forms, the signature page and the Rendering Provider Agreement must be signed by **both** an authorized official from the group and the rendering provider. Applications must be submitted within 30 days of the date the documents were signed.*

Since this module’s policies and procedures effective date, the time frame for receiving the signed application submission was extended from 30 days to 90 days from the date the IHCP Provider Agreement or the IHCP Rendering Provider Agreement is signed. Applications with provider agreements that are received beyond the 90 days will not be accepted and a new agreement will need to be submitted with updated signatures.

Copies of the appropriate certifications or licenses are required to be attached to the enrollment application for certain providers, depending on their provider type and specialty. The [IHCP Provider Enrollment Type and Specialty Matrix](#) is available online at in.gov/medicaid/providers for reference when determining supporting document and enrollment requirements.

Completed forms should be mailed to the Provider Enrollment Unit at the address provided on the form.

Note: Faxed enrollment packets and provider profile updates cannot be accepted unless specifically requested by the Provider Enrollment Unit. Due to the large volume of faxes Provider Enrollment receives daily, faxed documents may not remain intact. Providers should not send documents by overnight or express mail unless requested to do so by the Provider Enrollment Unit.

Enrollment Application Details

To enroll as an IHCP provider, the provider must do the following:

- Complete the appropriate online enrollment application or IHCP provider packet (based on provider type and classification).
- Sign the provider agreement and signature authorization sections. (The Portal accepts electronic signatures.)
- Submit applicable certifications or licenses required for the enrolling provider’s type and specialty. (The Portal allows electronic file transfer of attachments.)
- Provide proof of Medicare and Medicaid participation, when required.
- Provide fingerprint confirmation number if categorized as high-risk provider.
- Submit the documents to the Provider Enrollment Unit, either via the Portal or by mail.
- Pay the required application fee.

For online enrollment, follow instructions provided in the Portal. If enrolling by mail, see the following instructions for each component of the IHCP provider packet. Note that the specific sections of the enrollment application and information requested vary by provider type and classification. Follow the quality checklist and instructions in the beginning of the packet to help ensure that the enrollment application is completed and submitted correctly.

Note: Providers are encouraged to enroll online, using the [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers. Most of the following forms are built into the electronic application process, eliminating the need to submit them separately. When separate addendums are required, the Portal will prompt the provider to open, complete, and submit the addendum during the application process. The Portal also allows providers to upload required documentation, such as licenses, as electronic attachments.

Providers that apply through the Portal may still submit supporting documentation via the mail. However, all documents mailed must be received within 30 calendar days of the application being submitted and must be accompanied by the automated tracking number (ATN) coversheet associated with the electronic submission.

Depending on the provider type and classification, a provider enrollment application may contain the following sections:

- **Schedule A** – This section indicates who the provider is and what the provider would like to do:
 - **Type of Request** – Choose to enroll for the first time, perform a change of ownership, add a new service location, revalidate enrollment, or update existing information.

Note: An enrollment conversion option has also been added to the Type of Request field on the paper enrollment packet, for providers converting from an OPR enrollment to a rendering enrollment, or from a rendering enrollment to an OPR enrollment. For information on performing a Rendering/OPR conversion via the Portal, see the [Converting to OPR from Rendering or to Rendering from OPR](#) section.

- **Provider Information** – Provide requested provider information, including NPI, nine-digit ZIP Code, current and past IHCP enrollment status and IDs, and all relevant taxonomy codes (identifying healthcare provider type and specialty) associated with the NPI.

Note: If the NPI is used for multiple Provider IDs or service locations, identifiers such as ZIP+4 and taxonomy code will be used to identify the specific service location.

Healthcare provider taxonomy codes are designed to categorize the type, classification, and specialization of healthcare providers. More information about taxonomy, as well as a crosswalk between provider types and taxonomy codes, can be found on the [Taxonomy](#) page at cms.gov. Providers can also locate the taxonomy code assigned to the provider NPI through the [NPPES Registry](#) at cms.hhs.gov.

- **Contact Information** – Provide the name, telephone number, and email address for an individual who can answer questions about information provided in the packet. Also provide an email where provider publications can be sent.
Provide information about the following four addresses:
 - **Service Location Name and Address** identifies the address of the location where services are rendered and related records are kept. This address must be a physical location; a post office box or UPS store *cannot* be used.
 - **Legal Name and Home Office Address** must exactly match the name and address information on the W-9 (and the W-9 must be submitted with the application). The home office (legal) address must be the same for all IHCP service locations using the same taxpayer identification number (tax ID) – meaning the same federal employer identification number

(EIN) or Social Security number (SSN). The home office address is the legal address of the provider as reported to the IRS. The IHCP mails annual 1099 forms and other legal or tax-related communication to this address.

*Note: Any change to the home office (legal) address reported to the IHCP must be supported by a copy of the W-9 form showing the same change was reported to the IRS. The provider must separately update the home office (legal) address and the W-9 form on file for **each** affected IHCP-enrolled service location. See the [Address Changes](#) section for details.*

- **Mailing Name and Address** is the address where notifications and general correspondence is sent. A post office box is acceptable.
- **Pay-to Name and Address** is the location where the IHCP sends checks (if the provider is not set up for electronic funds transfer [EFT]) and general claim payment information. A post office box is acceptable. If the provider is using a billing agent, proof of authorization for the billing agent must be included as an attachment to the packet.
- **Provider Specialty Information** – Identify the provider type and primary specialty (see the [Provider Type and Specialty Requirements](#) section), any applicable additional specialties, and associated taxonomy codes.
- **Licensure/Certification:** Provide any requested license or certification information; required licensure and certification varies by provider type. A copy of the license or certificate from the appropriate board or authority must be included as an attachment to the packet. Providers may be required to provide:
 - Indiana State Department of Health (ISDH) certification information
 - Clinical Laboratory Improvement Amendments (CLIA) certification information
- **Schedule B** – This section identifies how the business is structured and other information:
 - **Organizational Structure** – Provide information about how the provider entity is legally organized and structured, whether it is registered to transact business in Indiana with the Secretary of State, incorporation status, and so on.
 - **Other IHCP Program Participation** – Note any additional IHCP programs to include in the enrollment, such as 590 Program, Preadmission Screening and Resident Review (PASRR), and Medical Review Team (MRT). (See the [Provider Enrollment for Specific IHCP Programs](#) section for details.)
 - **Dental Providers Only** – Dental providers indicate whether they are accepting new patients and whether they are equipped to handle patients with special needs requirements
 - **Medicare Participation** – Medicare providers must provide their Medicare identification numbers and associated service location address.
 - **Out-of-State Providers** – Out-of-state providers indicate whether they are currently enrolled in their state's Medicaid program. If so, proof of participation must be attached to the packet.
 - **Patient Population Information** – Indicate the funding sources for the patient population; be sure the percentages equal 100%.
- **Schedule C** – This section collects full and complete disclosure information, required by federal regulation, about ownership or control interest in the business entity (see the [Disclosure Information](#) section for definitions):
 - **Section C.1** must show **all** individuals and corporations with ownership or control interest in the provider entity, per the requirements stated in the schedule.
 - C.1.(A) must include the name, address, SSN, date of birth, and title (such as chief executive officer, owner, or board member) for each **individual** with ownership or control interest in the provider entity. If the individual is an owner, the percent of ownership is also required. Attach additional pages as needed.
 - C.1.(B) must include the name, tax ID, percent of ownership in the applicant, and the primary business address as well as every business location and P.O. box addresses for each

corporation with ownership or control interest in the provider entity. Attach additional pages if needed.

- **Section C.2** must list all subcontractors in which the applicant has a 5% or more ownership or control interest. This section may be marked as “not applicable” if it does not apply. The name, address, and tax ID for each subcontractor must be listed. Attach additional pages as needed.
- **Section C.3** must list all agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers or government-owned businesses must also list their managing individuals and board of directors.
- **Section C.4** must show familial relationships between individuals listed in previous sections of this schedule, and also, for the individuals noted, identify any past convictions. In addition, identify whether any of the owners included in C.1 have an ownership or control interest in another organization that would qualify as a disclosing entity.
- **IHCP Provider Signature Authorization** – This page must be signed by a person who is listed in the application as an individual with an ownership or control interest or a managing individual (in section C.1 or C.3 of Schedule C of the packet), and who has the authority to bind the provider to the terms of the provider agreement. The signer must also agree to abide by and comply with terms and conditions of the program. For group enrollments, an authorized official of the group or clinic provider must sign this page. For rendering providers, the provider must sign the *IHCP Provider Signature Authorization* section of the **rendering** provider packet (included within the group packet). Original signatures are required; a stamped signature is not acceptable. The Portal accepts electronic signatures.
- **IHCP Provider Agreement** – This document becomes the contract between the provider entity and the IHCP. Be sure to carefully read the agreement in its entirety. The agreement must be signed by the owner or authorized official ultimately responsible for operating the business. **A delegated administrator is not permitted to sign a provider agreement** (A *Rendering Provider Agreement* must also be completed for each rendering provider linked to a group.) Original signatures are required; a stamped signature is not acceptable. The Portal accepts electronic signatures.

The provider agreement is in effect for the entire period of an IHCP provider’s contract. The effective start date and end date of the provider’s contract are listed on the IHCP welcome letter. The IHCP welcome letter lists the following enrollment data from the provider profile:
 - Provider ID
 - NPI
 - Provider name as entered in the Core Medicaid Management Information System (*CoreMMIS*); must match name on license, if applicable
 - Enrollment effective start and end dates
 - Provider type and specialty
 - Taxonomy codes
 - Tax ID
 - All addresses, including home office (legal), mail-to, pay-to, and service location
 - EFT bank account and the bank’s routing number, when EFT is requested
- **IHCP Provider Federal W-9 Addendum** – Providers must submit the most current version of the W-9 from the [IRS website](https://www.irs.gov) at irs.gov. The legal name, doing business as (DBA) name (when applicable), and the address on the W-9 **must exactly match** the information in the *Legal Name and Home Office Address* section of the enrollment application.
- **IHCP Provider Application Fee Addendum** – Certain enrolling providers are subject to an application fee and must complete and submit this addendum with the provider enrollment packet. The [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#) provides a full list of provider types and indicates which types are subject to application fees.

- **IHCP Provider Screening Addendum** – Providers in the high-risk category must complete and submit this addendum with the enrollment application. See the [IHCP Provider Enrollment Risk Category and Application Fee Matrix](#).
- **IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form** – Providers that wish to have their claim payments deposited directly into a bank account need to complete the *IHCP Electronic Funds Transfer Addendum*, which is included in the enrollment packet, or use the Portal to add or change banking information for EFTs.
- **IHCP Provider Delegated Administrator Addendum/Maintenance Form** – This form allows the owner or authorized official completing the enrollment packet to grant authority to an additional trusted individual within his or her organization to submit claims, accept payment, or make selected changes to the provider information on file. Delegated administrators cannot sign a provider agreement on behalf of any owner or rendering provider.

*Note: Designating a delegated administrator grants that person permission to sign and submit **paper** documents only. To grant permission for the individual to submit claims, update provider information, and perform other tasks **online**, a Delegate account with the appropriate permissions must be created on the Portal for the individual.*

- **IHCP Provider Change of Ownership Addendum** – If an enrolled entity has experienced a change of ownership, this addendum must be completed and included with the enrollment packet submitted by the new owner. This information helps identify the entity that is affected by the change.
- **IHCP Hospital and Facility Additional Information Addendum** – Certain hospitals and extended-care facilities need to complete this one-page addendum when enrolling as an IHCP provider.
- **IHCP Psychiatric Hospital Bed Addendum/Maintenance Form** – For psychiatric hospitals that have 16 beds or less that wish to enroll in the IHCP, the *Psychiatric Hospital Addendum* must be completed and included with the enrollment packet. Federal regulation restricts reimbursement when a psychiatric hospital has more than 16 beds. See *42 CFR 435.1008(a)(2)*.
- **IHCP PRTF Attestation Letter/Maintenance Form** – Providers wishing to enroll as PRTFs must be licensed under *465 IAC 2-11* as private, secure, child-caring institutions. To enroll as PRTFs, facilities must comply with the requirements in *42 CFR 482, Subpart G* governing the use of restraint and seclusion, and submit an attestation letter stipulating that they comply with federal and State requirements. See *405 IAC 5-20-3.1(3)*. The *PRTF Attestation Letter* must be completed and included with the enrollment packet.
- **IHCP Outpatient Mental Health Addendum** – Providers wishing to enroll as an outpatient mental health clinic or as a community mental health center must complete and include the *IHCP Outpatient Mental Health Addendum*, which provides information about the supervising practitioner and a complete list of individual practitioners, who will provide outpatient mental health services, and their qualifications.
- **IHCP Rendering Provider Enrollment and Profile Maintenance Packet** – This enrollment packet allows a group provider to identify the practitioners associated with the group – those who actually provide the services offered by the entity. Only a group provider may enroll and link rendering providers employed by the group. A *rendering provider packet* must be completed for each practitioner providing care. The *IHCP Signature Authorization* section must be signed by both the rendering provider and the owner or authorized official of the entity. The *Rendering Provider Agreement* must also be signed by both the rendering provider and an authorized official of the entity. Both documents are required for enrollment.

The Provider Enrollment Unit verifies that all the packets' schedules, which include ownership disclosure and management information, are complete, appropriate signatures are present, date of birth and Social Security number are included for anyone listed on section C.1 or C.3 of Schedule C, licenses and credentials are enclosed, and other necessary documentation per the requirements specific to the provider's type and specialty is present before completing the request.

The [IHCP Provider Enrollment Type and Specialty Matrix](https://in.gov/medicaid/providers), available at in.gov/medicaid/providers, contains document requirements by provider type and specialty, and should be reviewed prior to submitting documents to the IHCP. If the enrollment packet is incomplete or the required documentation is not included, the Provider Enrollment Unit contacts the provider in an attempt to complete the application. If the application cannot be completed after contacting the provider, a letter is sent to the enrolling provider outlining what is missing.

Note: Be sure to keep a copy of all submitted forms for your records.

Disclosure Information

Federal program integrity regulations require states to obtain and validate certain disclosures from providers upon enrollment and periodically thereafter. When states obtain these disclosures and search exclusion and debarment lists and databases, they can take appropriate action on providers' participation in the Medicaid program.

Social Security numbers disclosed on an IHCP enrollment application or update are used to determine whether the persons and entities named are federally excluded parties. Refusal to provide a Social Security number will result in rejection of the application. Birth dates are also required to correctly identify the individual when performing sanction checks.

Providers must include disclosure information for **all** individuals and business entities that meet disclosure requirements. Nonprofit providers must list board of directors or advisory board as well as managing individuals.

Note: As defined in 42 CFR 455.101, a "person with an ownership or control interest" means a person or corporation that —

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;*
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;*
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;*
- (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;*
- (e) Is an officer or director of a disclosing entity that is organized as a corporation; or*
- (f) Is a partner in a disclosing entity that is organized as a partnership.*

Portal

Providers submit disclosure information through the Portal during the online enrollment or revalidation process. Providers can make changes to the disclosure information on file using the Portal *Provider Maintenance* page (Portal registration required).

The Portal allows users to enter the names of all owners and managers, and each individual's date of birth and Social Security number. The Portal requires entry of at least one owner and one manager during enrollment and revalidation. Additionally, the Portal requires percent ownership or control interest be listed for each person added to the disclosure panels, excluding managers.

Providers enter or update disclosure information in the following sections of the Portal according to the instructions provided:

- Individuals with an ownership or control interest and managing individuals
- Corporations with an ownership or control interest
- Subcontractors
- Additional disclosure information (relationship and background questions)

Schedule C

If providers are submitting a paper enrollment packet, disclosure information is included in Schedule C, which is divided into four sections: C.1 (A and B), C.2, C.3, and C.4. Providers must complete all four sections when applicable, and, at a minimum, C.1 and C.3 (N/A is not acceptable on section C.3), of the enrollment packet for disclosure information. When completing the Schedule C sections, whether during the initial application or to make changes as part of an update, make sure to include the names of ***all*** individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals will be replaced with the updated list of disclosed individuals.

C.1 – Disclosure Information – Individuals and/or Corporations with an Ownership or Control Interest in the Applicant

Providers use this section to list any person or entity that has an ownership or control interest in the provider entity.

Section C.1.(A) – Individuals with Ownership or Control Interest

Providers use this section to list any *individuals* that have an ownership or control interest, including officers, directors, or partners as defined in 42 CFR 455.101 sections (e) and (f).

If the entity is publicly held and no person owns 5% or more of the corporation, or if it is a not-for-profit or government-owned entity, complete fields 1a and 4a in this section. Then use section C.3 to list the board of directors or managing individuals as defined.

Section C.1.(B) – Corporations with an Ownership or Control Interest

Providers use this section to list ***all*** corporations with an ownership or control interest in the provider entity.

C.2 – Disclosure Information – Subcontractors

Providers use this section to list ***all*** subcontractors in which the applicant has a 5% or more ownership or control interest.

C.3 – Disclosure Information – Managing Individuals

Providers use this section to list *all* agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers and government-owned businesses must also list their managing individuals and board of directors. Sole proprietors must list owner name on C.1 and C.3.

- An agent is any person who has express or implied authority to obligate or act on behalf of an entity.
- An officer is any person whose position is listed as an officer in the provider’s articles of incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider’s board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word “director” in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, owner, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.

C.4 – Disclosure Information – Relationships and Background Information

This section has five different parts that need to be completed if applicable:

1. If any parties listed in sections C.1 or C.3 are related to each other as spouse, parent, child, or sibling, provide the name of each person and note their relationship.
2. If any parties listed in sections C.1 or C.3 are related to any individual with an ownership or control interest in any of the subcontractors listed in section C.2, provide the name of each person and note their relationship.
3. Indicate whether any persons or entities listed in section C.1 have an ownership or control interest in another organization that would qualify as a disclosing entity. If yes, list the name of each owner and the name of the other disclosing entities in which the owner has an ownership or control interest. If the entity is a nonprofit organization and does not have any owners, check NA.

Note: As defined in 42 CFR 455.101, “other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);*
- b) Any Medicare intermediary or carrier; and*
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.*

Whereas “disclosing entity” is limited to Medicaid providers, “other disclosing entity” can include entities that are not enrolled in Medicaid.

4. List any party with an ownership or control interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or Title XX services programs. Provide the name of the convicted party and the date of the conviction.

5. If any former agent, officer, director, partner, or managing employee, has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion, provide the names of both parties and note their relationship.

Nonrequired Provider Documents

Documents other than IHCP forms and the documents identified in the [IHCP Provider Enrollment Type and Specialty Matrix](#) are not required. The following examples of nonrequired documents need not be submitted with an enrollment or update request:

- Diplomas
- Certificates other than those noted in the [Provider Type and Specialty Requirements](#) section and the [IHCP Provider Enrollment Type and Specialty Matrix](#)
- Resumes and curricula vitae
- Lists of previous employment
- Lists of published works
- Letters of reference or commendation
- Medical doctors' insurance documents

Enrollment Confirmation

The enrollment effective start date for providers within the state of Indiana is the date the Provider Enrollment Unit receives the completed IHCP provider packet or online enrollment application. As such, providers should not begin treating IHCP members until confirmation is received that the enrollment paperwork has been processed.

Note: If the provider requests an enrollment effective date before the received date, federal requirements mandate that a copy of a paper claim form or remittance from a primary carrier be submitted with the application as proof of service rendered.

An enrollment confirmation letter is mailed to the provider upon successful enrollment in the IHCP. After receiving an enrollment confirmation letter, the provider can bill for covered services for dates of service that fall within the enrollment eligibility period.

Enrollment Denial or Rejection Appeal

An application to enroll in the IHCP can be denied if the screening process determines that the provider does not meet the requirements for participation, or an application can be rejected if required supporting documentation or information is missing from the submission. A letter is sent to notify providers of this decision and advise them of the necessary actions needed for resubmission of the rejected application.

Providers have the right to appeal an enrollment denial under *IC 4-21.5-3-7* and *405 IAC 1-1.4-12*. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.

The appeal should be sent to the following address:

MS07
Secretary, Indiana Family and Social Services Administration
c/o Gwen Killmer, Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204

If providers elect to appeal a determination, they must also file a statement of issues within 45 calendar days after receipt of notice of the determination. The statement of issues must conform to 405 IAC 1-1.4-12 and IC 4-21.5-3 and be sent to the same address as the appeal request.

Enrollment Tips – Avoiding Common Errors

Note: To eliminate the potential for the following errors and return of improperly completed enrollment packets, providers are encouraged to perform enrollment processes online via the Portal.

To help avoid delays in processing an application, review the following list of common reasons IHCP enrollment packets are returned to the provider:

- **Missing signature authorization addendum** – Enrollment packets must contain a signature authorization page signed by the owner or authorized official; for group enrollments, both the rendering provider and the owner or authorized official must sign the signature authorization section of each rendering provider packet.
- **Incomplete documents** – Examples include missing telephone numbers, specialty designations, license numbers, and banking information for EFTs. Be sure to complete all required provider agreements with all appropriate signatures.
- **Incomplete Schedule C, Sections C.1 (A and B), C.2, C.3, and C.4** – Sections C.1 and C.3 must be completed based on the business structure. Make sure that name, Social Security number, and date of birth are included for any listed individual. Refusal to provide a Social Security number results in rejection of the application.
- **Provider agreement missing from packet** – A current version of the *IHCP Provider Agreement* or *Rendering Provider Agreement* must be submitted for every provider that bills or renders services that are reimbursed by the IHCP. If an older, retired version of the agreement is submitted, it is rejected.
- **Incorrect signature on provider agreement** – A delegated administrator is not permitted to sign a provider agreement. The *IHCP Provider Agreement* must be signed by an owner, board member, or officer, with the signer being listed in section C.1 or C.3 of Schedule C. The *Rendering Provider Agreement* must be signed by the rendering provider and an authorized official of the entity.
- **Schedule A and W-9 inconsistent** – The legal name, DBA name, and tax identification information must be consistent on both the Legal Name and Home Office Address section of Schedule A and the W-9. If a DBA name is used, this name must match the name registered with the Secretary of State or the County Recorder's Office.
- **Current W-9 form missing** – Submit the most current W-9 available from the IRS; earlier versions are rejected and providers are asked to submit the most current version. Submission of a copy of the provider's IRS tax ID registration confirmation letter is helpful to support the tax ID reported to the IHCP.
- **Missing license or certificates** – Include a copy of the provider's professional license, if applicable. Include certificates that support the licensure specialty when a state does not license a specific specialty. See the [IHCP Provider Enrollment Type and Specialty Matrix](#) to determine documentation needs.

- **Additional service location not submitted on a separate application (with box checked)** – For each service location, submit a complete enrollment packet including Schedule A, Schedule B, Schedule C, *IHCP Provider Signature Authorization, W-9, IHCP Provider Agreement*, and any other addenda related to the service location. At the top of the Schedule A, check the box “Additional Service Location.”
- **Missing Rendering Provider Agreement** – For group enrollments, the enrollment packet must include a *Rendering Provider Agreement*, and the agreement must be signed by an authorized official of the group or clinic **and** the rendering provider.
- **EFT information errors** – EFT submissions must contain the appropriate bank routing and bank account numbers. To ensure timely payment, complete the EFT form included in the enrollment application or download a form from the [Update Your Provider Profile](#) page at in.gov/medicaid/providers.
- **Old form copies used to request enrollments and updates** – Use current forms found on the [Complete an IHCP Provider Enrollment Application](#) and [Update Your Provider Profile](#) pages at in.gov/medicaid/providers. The website permits providers and their staff members to complete the forms online and save the forms. Older versions of the forms are not processed.
- **Instructions not followed** – The enrollment and maintenance forms contain information about the form’s purpose and instructions about how to complete the forms. Read the forms’ instructions carefully and become familiar with required fields to avoid having the form rejected.

Provider Enrollment for Specific IHCP Programs

The following sections contain information for providers enrolling in specific IHCP programs.

Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment

To become a Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise managed care primary medical provider (PMP), providers must first enroll as an IHCP provider. The following IHCP provider specialties (associated with the provider types listed) qualify to enroll as PMPs with a managed care entity (MCE):

- 31 – *Physician*
 - 316 – Family Practitioner
 - 318 – General Practitioner
 - 328 – Obstetrician/Gynecologist
 - 344 – General Internist
 - 345 – General Pediatrician
- 10 – *Physician Assistant*
 - 100 – Physician Assistant
- 09 – *Advanced Practice Registered Nurse*
 - 090 – Pediatric Nurse Practitioner
 - 091 – Obstetric Nurse Practitioner
 - 092 – Family Nurse Practitioner
 - 093 – Nurse Practitioner (Other, such as clinical nurse specialist)
 - 095 – Certified Nurse Midwife

Providers may enroll in one or more of the programs with separate panels. Each PMP must designate a panel size; that is, the number of managed care members he or she is willing to accept.

HIP, Hoosier Care Connect, and Hoosier Healthwise MCE enrollment specifics are as follows:

- Qualifying physicians, physician assistants, and advanced practice registered nurses must be IHCP-enrolled prior to establishing their PMP enrollments.
- The prospective PMP must contact the MCEs to initiate the PMP enrollment process. The MCE verifies that the PMP is an IHCP-enrolled provider and sends a credentialing application and contract to the prospective PMP. After the PMP has been approved by the MCE's credentialing committee and has an executed provider contract on file, the MCE submits the PMP's enrollment information through the Portal for the PMP's enrollment into *CoreMMIS*. PMPs may enroll with one or more MCEs.
- Rendering providers must be linked to an IHCP group prior to being linked to a group practice or clinic in the HIP, Hoosier Care Connect, and Hoosier Healthwise managed care programs. All updates to IHCP enrollment information (address, EFT, linkage, and other similar changes) must be submitted via the Portal or on the appropriate form to the Provider Enrollment Unit for processing prior to submission of PMP enrollment changes. The forms are available by request from the Provider Enrollment Customer Assistance telephone line at 1-800-457-4584 or can be downloaded from the [Update Your Provider Profile](#) page at in.gov/medicaid/providers.

DXC reports PMP-related updates to the appropriate MCE.

Provider Enrollment in the Medical Review Team Program

Participation in the MRT program requires IHCP enrollment. Providers must enroll with the MRT program to submit claims for payment of MRT services. Nonlicensed providers are eligible to enroll as providers under the MRT program for reimbursement of medical records copying and provision only. To complete the enrollment process for the MRT program, prospective providers must complete the designated area that applies to the MRT program.

Newly Enrolling Providers Wanting to Provide MRT Services

New providers that want to participate in the MRT program follow the appropriate enrollment process for their provider type and category, either on the Portal or by submitting the appropriate provider packet downloaded from the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers.

The *Other IHCP Program Participation* section of the application allows the enrolling provider to indicate the desired option:

- Providers wishing to participate in the MRT program in addition general IHCP enrollment (Medicaid or Hoosier Healthwise Package C participation), select **Medical Review Program/IHCP**.
- Providers enrolling for MRT assessment services, but no other IHCP programs, select **Medical Review Program Only**.
- Providers enrolling in the MRT program as a copy center to bill only for the copying and provision of medical records, when medical record copies are requested by the MRT, select the **Medical Review Program – Medical Records Only**. These providers follow the Portal or paper enrollment process for a billing provider, using provider type 34 – *MRT Copy Center*.

All newly enrolling providers must complete the enrollment application in full, as described in the [Provider Enrollment Steps](#) section of this module. The completed application – including signed *IHCP Provider Signature Authorization* addendum and signed *IHCP Provider Agreement* – must be submitted along with a current *W-9* form and any documentation required for their provider type and specialty (see the [IHCP Provider Enrollment Type and Specialty Matrix](#)). For MRT copy centers enrolling for medical records services only, no additional documentation, other than the *W-9*, is required with the application.

Note: To provide MRT services, providers must have one of the Medical Review Program options selected in the Other IHCP Program Participation section of the provider profile.

Existing Providers Adding MRT Enrollment

Existing IHCP providers can indicate a desire to participate as an MRT provider by submitting an update via the Portal or by mail:

- On the Portal, select **Other Information Changes** on the *Provider Maintenance* page and then, in the *Other IHCP Program Participation* section, select **Medical Review Program/IHCP** to add MRT participation to the existing IHCP enrollment.
- To send the update by mail, submit the appropriate provider packet (based on provider type and category) from the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers, completed as follows:
 - Select **Profile Update** in the *Type of Request* section (in Schedule A).
 - Complete the *Provider Information* section (in Schedule A).
 - Go to the *Other IHCP Program Participation* section (in Schedule B) and select **Medical Review Program/IHCP** to add MRT participation to the existing IHCP enrollment.
 - Complete the *IHCP Signature Authorization* addendum (located after Schedule C). The addendum must be signed by an owner, authorized official, or delegated administrator.

Preadmission Screening and Resident Review Level II Provider Enrollment

The nursing facility Preadmission Screening and Resident Review (PASRR) was federally mandated under the 1987 *Nursing Home Reform Act*. All individuals applying for admission to Medicaid-certified nursing facilities, regardless of their source of payment, must be prescreened through the PASRR Level I process to identify those individuals who may have mental illness (MI), intellectual disability/developmental disability (ID/DD), or both (MI/ID/DD):

- Nursing facility residents identified as possibly having MI are referred to the Division of Mental Health and Addiction (DMHA) contractor for PASRR Level II assessments.
- Nursing facility residents identified with possible ID/DD or MI/ID/DD are referred to the Division of Disability Rehabilitative Services (DDRS) contractor for PASRR Level II assessments.

Nursing facility residents may also require assessment under the Resident Review Level II process if they are identified as one of the following:

- Possibly having MI, ID/DD, or MI/ID/DD and were not assessed through the PASRR program prior to admission
- Have had a significant change in condition related to their MI or ID/DD condition that may require a change in services or placement

For details about PASRR processes, see the [Long-Term Care](#) module.

All PASRR Level II providers are required to be enrolled in the Medicaid or Hoosier Healthwise Package C program. PASRR Level II providers must be contracted and approved by the DDRS or the DMHA. The appropriate State agencies must determine provider eligibility and send a letter of notification – approval or disapproval – to the provider. This letter is required for IHCP enrollment.

For providers contracted with the DDRS or DMHA, PASRR program participation can be indicated upon initial enrollment with the IHCP or added as an update to the enrolled provider's information on file.

Newly Enrolling Providers Wanting to Provide PASRR Level II Assessments

Providers not already enrolled in the IHCP are encouraged to use the Portal to enroll, or they can download and submit the appropriate IHCP provider packet from the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers. The provider must complete the application in full and comply with any requirements for their provider type, as indicated in the [IHCP Provider Enrollment Type and Specialty Matrix](#).

To indicate participation in the PASRR program, the provider must select **Yes** to the question “Contracted to provide PASRR services?” on the Portal enrollment or, on the paper enrollment packet, check the **Yes** box in the Participate in the PASRR Program field. A copy of the DDRS or DMHA PASRR approval letter must be submitted with the IHCP enrollment application.

Existing Providers Adding PASRR Level II Participation

Existing IHCP providers that have been approved by the DDRS or DMHA to provide PASRR services may add PASRR participation to their enrollment via the Portal or by mail:

- On the Portal, select **Other Information Changes** on the *Provider Maintenance* page and then, in the *Other IHCP Program Participation* section, select **Yes** for “Contracted to provide PASRR service.”
- To send the update by mail, submit the appropriate provider packet (based on provider type and category) from the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers, completed as follows:
 - Select **Profile Update** in the *Type of Request* section (in Schedule A).
 - Complete the *Provider Information* section (in Schedule A).
 - Go to the *Other IHCP Program Participation* section (in Schedule B) and choose **Yes** in the box marked Participate in the PASRR Program.
 - Complete the *IHCP Signature Authorization* addendum (located after Schedule C); the addendum must be signed by an owner, authorized official, or delegated administrator.

Whether the update is submitted via the Portal or by mail, a copy of the DDRS or DMHA PASRR approval letter must be attached.

Section 4: Provider Profile Maintenance and Other Enrollment Updates

The *provider profile* is the provider enrollment information on file with the Indiana Health Coverage Programs (IHCP). This information is an integral reference for provider participation and claim processing.

To maintain the accuracy of the provider profile, providers must notify IHCP Provider Enrollment within **30 business days** of any changes in the following information:

- Provider address, including changes to a mail-to, pay-to, service location (practice site), or home office (legal) address
- Medicare provider number
- Addition to or removal of a rendering provider from the group
- Specialty
- Taxpayer identification number (tax ID)
- Legal name or doing business as (DBA) name
- Ownership
- Electronic funds transfer (EFT) account information
- Enrollment status (disenrollment requests)

Providers must notify IHCP Provider Enrollment within **10 business days** of any changes in the following information:

- Licensure
- Certification, including Clinical Laboratory Improvement Amendments (CLIA) certification
- Permit

Delays in submitting this information to Provider Enrollment may result in erroneous payments or denials.

Note: Provider profile information can be viewed and updated online by providers that have a registered account on the IHCP Provider Healthcare Portal (Portal), and by registered delegates with appropriate permissions. For information about registering Provider and Delegate accounts on the Portal, see the [Provider Healthcare Portal](#) module.

Provider Profile Update Methods

Changes to current provider profile data must be approved by written request from the provider or authorized delegate or by direction from the FSSA. Provider profile information can be updated electronically on the Portal or changes can be submitted by mail, using the appropriate maintenance form located on the [Update Your Provider Profile](#) page at in.gov/medicaid/providers. Providers can also submit an IHCP provider packet with updates.

Providers must indicate the NPI and appropriate provider name on all correspondence. Delays in submitting this update information to Provider Enrollment may result in erroneous payments or denials.

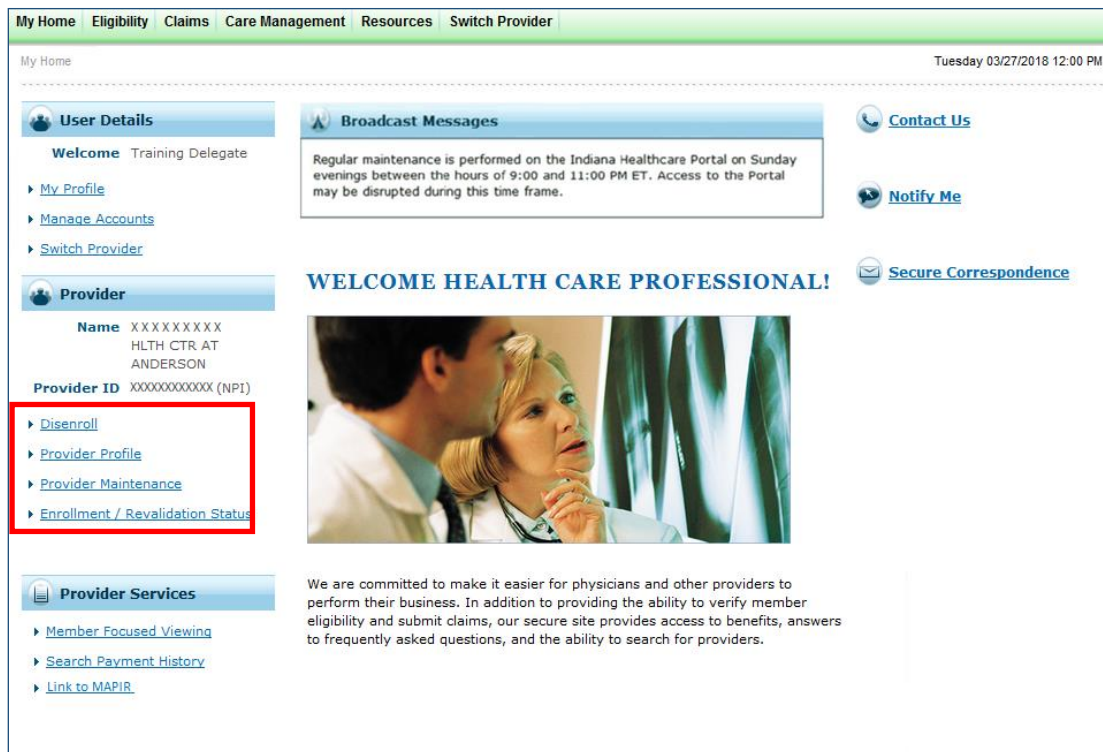
Viewing and Updating Provider Profile Information via the Portal

Registered Portal users with appropriate administrative permissions have the ability to view provider information online and to update the information electronically, rather than by sending a paper form. The Portal is the preferred method of update submission, because the online process is faster and includes online help functions.

Information about registering a Portal account and assigning administrative permissions can be found in the [Provider Healthcare Portal](#) module.

Most provider profile functions are available from the *My Home* page (see Figure 7), after the user has logged into the Portal. Some functions (such as revalidation, change in ownership, and adding a service location) require the user to log out and create a new enrollment from the Portal home page.

Figure 7 – Provider Options on the My Homepage of the Portal



View Provider Profile Information

Registered Portal users can view provider profile information online using the **Provider Profile** link on the *My Home* page. Group providers are also able to view information for all the rendering providers associated with their practice.

Note: To view provider profile information in the Portal, registered delegates must have the appropriate permission assigned to their account.

The following provider information is viewable in the Portal:

- Rendering provider information, such as primary medical provider (PMP) information, and the start and end dates of current and historical rendering linkages, when viewing a group's profile
- PMP information for individual rendering providers when viewing a group's profile

- Current and historical group linkages for a rendering provider when viewing a rendering provider's profile
- Current and historical NPI and IHCP Provider ID information
- All address information associated with an IHCP Provider ID
- Current and historical license information
- Current and historical CLIA information
- Current and historical contract and program information with start and end dates
- Current taxonomy codes
- Current Medicare participation information
- Recertification dates, when applicable
- Revalidation dates, when applicable

Figure 8 – Provider Profile Details

Provider Profile Details			
Provider ID	Provider Type	31-Physician	
NPI			
Provider Name			
Print Profile			
General Name / Address Specialties Licenses Medicare			
Organization Information			
Organization Individual/Sole Proprietor Revalidation Date 07/25/2022 Recertification Date _			
Contract Information			
Program	Effective Date	End Date	Status
Anesthesia	12/07/2017	—	Retired
Audiology	12/07/2017	—	Retired
Chiropractor	12/07/2017	—	Retired
Diabetes SMT	12/07/2017	—	Retired
Drugs	12/07/2017	—	Retired
Durable Medical	12/07/2017	—	Retired
Laboratory	12/07/2017	—	Retired
Medical Services	12/07/2017	—	Retired

Provider Maintenance Options

The **Provider Maintenance** link in the Provider section of the Portal's *My Home* page allows users to submit changes to the provider information reported to the IHCP.

The Provider Maintenance function is available to any user within the provider's organization who has been granted access to this function by his or her provider representative (or by an authorized delegate). To modify delegate access to these functions, see the instructions in the [Provider Healthcare Portal](#) module. It is the provider representative's responsibility to grant Provider Maintenance access to only the appropriate delegates. By limiting personnel who have access to this function, providers can prevent unauthorized changes to provider information. Providers should ensure that users do not share their user IDs and passwords.

At *My Home* page, click the **Provider Maintenance** link to view the *Provider Maintenance: Instructions* panel. If there are no pending requests, the *Current Maintenance Pending Requests* section displays the message: *There are no Pending Maintenance Requests to show*. If there are pending requests, a message will appear indicating pending requests, and the section associated with the pending requests will appear grayed out and cannot be accessed until updates are finalized.

Figure 9 presents the *Provider Maintenance: Instructions* panel. Table 1 provides information about the options available from this panel. See the [Provider Profile Maintenance](#) section for details about these options.

Figure 9 – Provider Maintenance: Instructions

Table 1 – Provider Maintenance Options

Maintenance Options	Description
Change of Ownership (CHOW) Overview	Provides information about how to report a change of ownership.
Tax ID Changes	Allows users to update Social Security number or federal employer identification number (EIN) information, as long as the change is not a change of ownership. Submission of a W-9 is required when making the change.
Contact and Delegated Administrator Information Changes	Allows maintenance of contact information and delegated administrators: <ul style="list-style-type: none"> Contact information corresponds to the individual to be contacted with questions about this location. Delegated administrators are the individuals entered (during initial IHCP enrollment) for paper submissions only. <i>This option is not related to the task of registering delegates in the Portal.</i>
Address Changes	Allows users to modify registered home office (legal), mail-to, pay-to, and service location addresses. Home office (legal) address change requires submission of W-9 and must exactly match the home office (legal) address reported to the IRS on the W-9. Dental providers can also use this option to indicate whether they are accepting new patients or patients with special needs.

Maintenance Options	Description
Specialty Changes	Allows users to add or remove provider specialties and change primary specialty assignment. Additional specialties can be added to an existing profile, unless restricted by type/specialty; for example, transportation and waiver providers may not change specialty, and no high- or moderate-risk specialty can be added or changed (cannot change primary specialty).
Presumptive Eligibility Changes	Allows appropriate provider types to enroll as a qualified provider (QP) for the Presumptive Eligibility (PE) or Presumptive Eligibility for Pregnant Women (PEPW). Only certain specialties can enroll as qualified providers, and some are restricted to PEPW only. For more information, see the Presumptive Eligibility module.
EFT Changes	Allows users to enroll in electronic funds transfer (EFT) or change existing EFT information. It takes approximately 18 days for the bank to process and completely establish an EFT account. If claims are paid before an EFT is active, paper checks will be mailed to the <i>pay-to</i> address on file.
Language Changes	Allows users to add languages for which they are able to interpret. This field is not required.
ERA Changes	Allows users to sign up to receive claim payment information using electronic remittance advance (ERA) 835 transactions. If ERA 835 transactions are to be electronically exchanged, an account should be established using this page within the maintenance application.
Other Information Changes	Provides ability to enroll in IHCP programs such as the 590 Program, Preadmission Screening and Resident Review (PASRR), and Medical Review Team (MRT). The access to change or view these options will only appear to providers whose type and specialty are appropriate.
Rendering Provider Changes	Allows group users to add or remove rendering providers linked to the group provider.
Provider Identification Changes	Allows users to change provider identification data, which includes: <ul style="list-style-type: none"> • Legal name • Doing business as (DBA) name • Organizational structure • NPI • Taxonomy information • Licensure and certificate information including Clinical Laboratory Improvement Amendments (CLIA) certification • Medicare participation • Patient population • Drug Enforcement Agency (DEA) information These changes are not intended to report the sale or transfer of ownership of the enrolled entity.
Disclosure Changes	Allows users to report any new or departing owners, board members or managers and maintain address information for all disclosed individuals (owners and managers, individuals, and corporations). Do not use the <i>Disclosure Changes</i> link to report CHOW information.
Check Status	Allows users to check the status of their change request using the tracking number assigned during the submission process and the provider's federal tax identification number (tax ID) – employer identification number (EIN), or Social Security number (SSN).

Check Status

Each time a provider maintenance change request is submitted, a tracking number is assigned. Be sure to make a note of the tracking number for future reference, so that you can check the status of your request.

Figure 10 – Provider Maintenance: Tracking Information

To check the status of your request, click **Check Status** from the left menu of the *Provider Maintenance Instructions* page and enter the tracking number and the tax ID (EIN or SSN).

Figure 11 – Provider Maintenance: Status

Submitting Provider Profile Updates by Mail

IHCP provider packets and profile maintenance forms are available for providers that choose to update their information by mail rather than via the Portal. Updates submitted by mail using anything other than the appropriate forms are not accepted and are returned to the provider. An authorized owner or officer of the company must sign the form.

The provider profile maintenance (update) forms enable providers to request very specific changes to their current information on file. The following maintenance forms are available on the [Update Your Provider Profile](#) page at in.gov/medicaid/providers:

- *IHCP Provider Disenrollment Form* is used to voluntarily disenroll from the IHCP.
- [IHCP Rendering Provider Enrollment and Profile Maintenance Packet](#) can be used to update an enrolled rendering provider or to terminate a rendering provider's linkage to a service location.
- *IHCP Provider Enrollment Recertification of Licenses and Certifications Form* is used for providers that are required to recertify their enrollment credentials to continue to be enrolled with the IHCP. The recertification form must be accompanied by supporting documentation as indicated on the [IHCP Provider Enrollment Type and Specialty Matrix](#).
- *IHCP Provider CLIA Certificate Maintenance Form* is only used when there is a change to the level of CLIA certification a provider has been granted.

- *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form* is used to request EFT instead of paper checks or to change direct-deposit information.
- *IHCP Provider Medicare Number Maintenance Form* is used to update Medicare numbers.
- *IHCP Provider Name and Address Maintenance Form* is used to update any of the four address types (home office [legal], mail-to, pay-to, or service location) and for a change of legal name or doing business as (DBA) name that is not the result of a change of ownership.
- *IHCP Provider Specialty Maintenance Form* is used to request a change to the specialty.
- *IHCP Provider Taxpayer Identification Number Maintenance Form* is used to make a change to the tax ID when it is not related to a change in ownership or transfer of assets.
- *IHCP Provider Delegated Administrator Addendum/Maintenance Form* is used to grant, change, or revoke authority for a specific individual to sign and submit certain documents on behalf of the provider. The form contains a list of the documents for which authority may be delegated.
- *IHCP MRO Clubhouse Provider Enrollment Addendum* is used to make changes to the disclosed individuals associated with a rendering MRO Clubhouse provider organization. This form applies to clubhouse providers rendering services through an IHCP-enrolled MRO provider.
- *IHCP Psychiatric Hospital Bed Addendum/Maintenance Form* is used to determine if your facility qualifies for reimbursement as a 16-bed or less psychiatric facility. This form applies only to provider type 01 – *Hospital*, specialty 011 – *Psychiatric*.
- *IHCP PRTF Attestation Letter/Maintenance Form* is used for the “Psych Under 21 Rule” that requires PRTF facilities to provide attestations of compliance each year by July 21 (or by the next business day if July 21 falls on a weekend or holiday). This form applies only to provider type 03 – *Extended Care Facility*, specialty 034 – *Psychiatric Residential Treatment Facility*. Use this form when submitting the annual attestation.
- *Internal Revenue Service (IRS) Form W-9*, referred to as *W-9*, is used with the submitted enrollment packet or update form. Please follow [IRS instructions for completing the W-9](#) at [irs.gov](#). IRS states the following for disregarded entities: For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a “disregarded entity.” See *Regulations section 301.7701-2(c)(2)(iii)*.
 - Enter the owner’s name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign limited liability corporation (LLC) that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner’s name is required to be provided on line 1.
 - If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity’s name on line 2, “Business name/disregarded entity name.”
 - If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate *Form W-8* instead of a *W-9*, even if the foreign person has a U.S. tax ID.

To submit an update for which no stand-alone form exists, you must submit your updates using the appropriate *IHCP Provider Enrollment and Profile Maintenance Packet* and indicate **Profile Update** for the Type of Request (in *Section A*). The IHCP provider packet can also be used to make multiple updates in a single submission. For example, a provider would use the packet specified by his or her provider type and classification to report an address change, a new EFT account, and Medicare numbers at the same time.

Send all IHCP provider packets and profile maintenance forms to DXC at the following address:

Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Provider Profile Maintenance Details

Providers must report any changes to their information on file to the IHCP. Most provider updates can be made through the Portal (for registered Portal users with appropriate permissions). Some changes may require users to submit or upload additional supporting documentation before the change is finalized in the system.

Tax ID Changes

Providers must report a change to their tax ID (Social Security number [SSN] or federal employer identification number [EIN]), either by mail, using the [IHCP Provider Taxpayer Identification Number Maintenance Form](#) or via the *Provider Maintenance* page of the Portal as follows:

1. Select the **Tax ID Changes** link to access the *Provider Maintenance: Tax ID Changes* panel (Figure 12).
2. Enter the new number.
3. Select either EIN or SSN.
4. Click **Submit**.

Figure 12 – Provider Maintenance: Request Tax ID Changes

For all tax ID changes, whether submitted by Portal or by mail, providers are required to submit a W-9 verifying the new EIN or SSN provided. A copy of the IRS tax ID registration confirmation letter is required to support the new number.

Tax ID changes resulting from a change of ownership (CHOW) require completion of an IHCP enrollment application. See the [Change of Ownership](#) section.

Contact and Delegated Administrator Information Changes

IHCP providers can grant, change, or revoke authority for a specific individual to sign and submit certain documents on behalf of the provider. Delegated administrator information may be submitted by mail, using the *IHCP Provider Delegated Administrator Addendum/Maintenance Form*, or via the Portal by selecting the **Contact and Delegated Administrator Information Changes** link on the *Provider Maintenance* page and making changes as instructed.

*Note: A delegated administrator is an individual that the provider designates, during initial IHCP enrollment, as having the authority to submit provider profile updates by mail on the provider's behalf. Delegated administrators are authorized for paper submissions only. This option is **not** related to the task of registering delegates in the Portal to submit updates online.*

Figure 13 – Provider Maintenance: Contact and Delegated Administrator Information

Provider Maintenance: Contact and Delegated Administrator Information ?

You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request. The contact person will potentially be contacted to answer any questions regarding the information provided in this change request.

* Indicates a required field.

Contact Information

The contact name and email relate to the person who can answer questions regarding this location. Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.

*Last Name

*First Name

Title

*Telephone Number Telephone Number Extension

Fax Number

*Contact Email

*Confirm Email Address

Preferred Method of Communication

Delegated Administrator Information

Delegated Administrators are identified for paper submissions, and upon initial enrollment on the portal. Delegated Administrators are not registered portal delegates. Portal delegates are registered and maintained on the Manage Accounts page under User Details on the Home page. Portal delegates are made to allow users access to maintain provider data on the portal, and are not used for paper submissions. Delegated Administrators are only needed and used for paper submissions, and were entered upon initial enrollment, which is prior to the registering delegates task. This page is only used to maintain Delegated Administrators and is not for maintaining your registered portal delegates.

Delegated Administrator Name	Effective Date	Action
<input type="checkbox"/> Click to collapse.		
Delegated Administrator Signature <input type="text"/>	Effective Date 08/09/2017	
<input type="button" value="Add"/>		

Address Changes

It is extremely important that address information is current, because out-of-date address information can affect provider payment and receipt of program-related correspondence. DXC maintains four addresses on file for each billing provider or group provider service location. The four addresses and their uses are listed in [Table 2](#). All addresses must be current to avoid returned mail.

Providers that fail to maintain their address information are subject to termination if mail is returned to DXC without a forwarding address. Provider Enrollment uses forwarding addresses to request an address update from providers, not to update information in *CoreMMIS*.

Table 2 – Provider Enrollment File Addresses

Address Name	Correspondence
Home office (legal) address (corporate office or headquarters)	<ul style="list-style-type: none"> • 1099s • IRS information
Mail-to address	<ul style="list-style-type: none"> • Provider update and enrollment confirmation letters • Recertification Notice • Revalidation Notice • Special correspondence
Pay-to address	<ul style="list-style-type: none"> • IHCP payments • PMP disenrollment letters
Service location address	<p>Physical location where services are rendered or claim documentation can be reviewed.</p> <p><i>Note: The service location 9-digit ZIP Code is also used in the billing provider NPI crosswalk process for claim submission.</i></p>

If a provider's pay-to address is not up to date, resulting in a check being mailed to the wrong address, DXC will not send a replacement check to the provider until the pay-to address is updated in CoreMMIS.

Important: Any changes to the home office (legal) address reported to the IHCP require the submission of a W-9 showing the same change was reported to the IRS. Updated W-9 forms **must** be submitted using the version of the W-9 currently posted on the IRS website. Providers should go to the IRS website each time a new W-9 form is needed to make sure the correct version is being submitted.

If an existing provider moves his or her home office, the provider must separately update the home office (legal) address and the W-9 form on file for **each** affected IHCP-enrolled service location.

Update an Address

To ensure that their address information in CoreMMIS is regularly maintained, providers can submit updates by mail, using the [IHCP Provider Name and Address Maintenance Form](#), or online via the Portal's *Provider Maintenance* page as follows:

1. Select the **Address Changes** link to access the *Provider Maintenance: Addresses* panel ([Figure 14](#)).
2. Click the plus sign (+) to the left of each address type to view or change the details for the addresses on file:
 - Mail-To
 - Pay-To
 - Legal (home office)
 - Service Location

All four addresses are required.

Note: To add an additional service location for a billing provider, or to entirely remove a service location, providers must follow the instructions in the following sections.

Figure 14 – Provider Maintenance: Addresses
(With Service Location Address Expanded)

Provider Maintenance: Addresses ?

You are initiating a change request. Complete the desired changes and click the "Submit" button to submit this change request.

When adding or changing a Legal address, a new W-9 will be required as an attachment in this request.

* Indicates a required field.

Provider Addresses

The provider addresses identify the various addresses associated with the provider location, including those used for billing and payment. All four address types are required: Service Location, Legal, Pay To and Mail To.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **Remove** to remove the entire row.

	Type	Street	City	State	Action
<input type="checkbox"/>	Service Location			Indiana	Copy Remove
<p>*Address Type <input type="text" value="Service Location"/></p> <p>*Service Location (DBA) Name <input type="text"/></p> <p>*Street <input type="text"/></p> <p>*City <input type="text"/> *County <input type="text"/></p> <p>*State <input type="text" value="Indiana"/> *ZIP Code <input type="text"/></p> <p>This address information must be verified each time that it is changed. Please click the Verify Address button below each time the address is changed. The address cannot be saved until it has been verified.</p> <p>Verify Address</p> <p>Email Address <input type="text"/> Confirm Email Address <input type="text"/></p> <p>*Telephone Number <input type="text"/> Telephone Number Extension <input type="text"/></p> <p>Fax Number <input type="text"/> Fax Extension <input type="text"/></p> <hr/> <p>Service Address Information</p> <p>If 'Address Type' is changed from 'Service', the service information below will be lost upon Add or Save of address.</p> <p>DEA # <input type="text"/></p> <hr/> <p>Claim Documentation <input type="checkbox"/> Kept Here</p> <hr/> <p>Save Reset Cancel</p>					
<input type="checkbox"/>	Mail To		INDIANAPOLIS	Indiana	Copy Remove
<input type="checkbox"/>	Pay To		INDIANAPOLIS	Indiana	Copy Remove
<input type="checkbox"/>	Legal		INDIANAPOLIS	Indiana	Remove

You have reached the maximum number of addresses allowed for this list.

[Submit](#) [Cancel](#)

Add a Service Location (Practice Site)

To add a new service location, providers must complete a new provider enrollment application. Providers must complete a separate application (online or using the appropriate provider packet) to enroll each new service location. For provider types considered at moderate or high risk for fraud, an unannounced site visit must be successful before a new service location can be added.

To add a new service location, follow instructions for new enrollment, except as follows:

- On the Portal, select **Add a Service Location** for Enrollment Request Type (see Figure 15).
- In the provider packet, select **New Service Location** in the *Type of Request* section of Schedule A

Figure 15 – Adding New Service Location

Provider Enrollment: Request Information

[Welcome](#)

You are initiating a new Indiana Health Coverage Programs (IHCP) enrollment application. Complete the fields on each page and click **Continue** to move forward to each page. All required fields on a page must be completed before the **Finish Later** option can be selected.

• Indicates a required field.

Request Information

Addresses

Specialties

Provider Identification

Languages

EFT Information

Other Information

Disclosures

Additional Disclosures Information

Initial Enrollment Information

• **Provider Classification** ?

• **Provider Type** ?

• **Requested Enrollment Effective Date** 04/12/2019 ?

To request a date prior to today's date, a written request explaining the need for the earlier date, plus supporting documentation, must be submitted with application.

• **Enrollment Request Type** ?

New Enrollment
Change of Ownership
Add Service Location

Close a Service Location

To disenroll a service location, providers may either use the Disenroll link on the Portal's *My Home* page (if they are registered Portal users) or submit an [IHCP Provider Disenrollment Form](#). Providers should indicate on the form which service location they want to deactivate. An authorized official listed in section C.1 or C.3 of Schedule C must sign the form to ensure processing. Failure to indicate the request type or to include an authorized official's signature will result in the return of the document.

If the service location has active PMPs linked to it, the provider must contact the appropriate MCE to complete the PMP disenrollment before being able to deactivate a location.

Specialty Changes

Providers can add, change, or delete a specialty. See the [IHCP Provider Enrollment Type and Specialty Matrix](#) for enrollment requirements for each provider type and specialty.

Changes to a specialty can be made online using the **Specialty Changes** option on the *Provider Maintenance* page of the Portal, or by mail using the [IHCP Provider Specialty Maintenance Form](#).

Figure 16 shows a physician provider specialty being added on the Portal.

Figure 16 – Provider Maintenance: Specialties

Provider Maintenance: Specialties

Specialties

You are initiating a change request for specialty information.

- You may add, change, or delete a specialty.
- Please select and add **ALL** specialties that apply to you.
- Only one specialty can be indicated as primary. Complete the desired changes and select the Submit button to submit the change request.
- Upon submission, at least one specialty must be associated with the provider.

* Indicates a required field.
☒ Indicates a primary specialty.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **Remove** to remove the entire row.

	Specialty	Action
<input checked="" type="checkbox"/>	316 : Family Practitioner	
<input checked="" type="checkbox"/>	314 : Dermatologist	Remove
<input type="checkbox"/>	Click to collapse.	

Provider Type 31 : Physician
Primary ☐

***Specialty**

- 310 : Allergist
- 311 : Anesthesiologist
- 312 : Cardiologist
- 313 : Cardiovascular Surgeon
- 314 : Dermatologist
- 315 : Emergency Medicine Practitioner
- 316 : Family Practitioner
- 317 : Gastroenterologist
- 318 : General Practitioner
- 319 : General Surgeon
- 320 : Geriatric Practitioner
- 321 : Hand Surgeon
- 323 : Neonatologist
- 324 : Nephrologist
- 325 : Neurological Surgeon
- 326 : Neurologist
- 327 : Nuclear Medicine Practitioner
- 328 : Obstetrician/Gynecologist
- 329 : Oncologist
- 330 : Ophthalmologist
- 331 : Orthopedic Surgeon
- 332 : Otolologist, Laryngologist, Rhinologist
- 333 : Pathologist
- 334 : Pediatric Surgeon
- 336 : Physical Medicine and Rehabilitation Practitioner
- 337 : Plastic Surgeon
- 338 : Proctologist
- 339 : Psychiatrist
- 340 : Pulmonary Disease Specialist

Presumptive Eligibility Changes

To enroll as a qualified provider (QP) for the Presumptive Eligibility (PE) process, providers must be registered Portal users. To initiate the QP enrollment process, go to the *Provider Maintenance* page, select **Presumptive Eligibility Changes**, and complete the fields as instructed.

Not all provider types and specialties are eligible to enroll as a QP. Additionally, depending on provider type and specialty, a provider may have the option to enroll as a QP for all PE determinations or for Presumptive Eligibility for Pregnant Women (PEPW) only. See the [Presumptive Eligibility](#) module for more information and instructions.

Existing QPs can terminate their QP status by selecting the appropriate check box.

Electronic Funds Transfer Changes

Changes that affect a provider's account and routing number must be reported to avoid a failed electronic funds transfer of claim payments. To ensure the accuracy of EFT information in *CoreMMIS*, billing providers initiating or changing EFT information must submit the information via the Portal (by selecting the **EFT Changes** option on the *Provider Maintenance* page) or by mail, using the [IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form](#).

Figure 17 shows the *Provider Maintenance: EFT Information* panel of the Portal. To authorize the IHCP to establish a direct deposit account for electronic funds transfers, or to change account information for an existing direct deposit account, complete all information as instructed.

See the [Financial Transactions and Remittance Advice](#) module for additional information about EFT.

Figure 17 – Provider Maintenance: EFT Information

Provider Maintenance: EFT Information ?	
<p>You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.</p> <p>Providers that would like to have their claim payments deposited into a bank account should enter their relevant information below.</p> <p>The Indiana Health Coverage Programs (IHCP) will establish a direct deposit account with your financial institution for claims payment. After you have established electronic funds transfer (EFT), the IHCP will electronically transfer payments into the account you specify on this form.</p> <p>It takes approximately 18 days for the bank to process and completely establish your EFT account. If you bill claims before your EFT activation, paper checks will be mailed to the Pay To address documented. When your EFT account becomes active, direct deposits begin.</p> <p>* Indicates a required field.</p>	
Provider Identifiers Information	
<p>Provider Federal Tax Identification Number (TIN), *****XXXX Employer Identification Number (EIN) or Social Security Number (SSN)</p> <p>Provider National Provider Identifier (NPI) XXXXXXXXXXX</p>	
Provider Agent Information	
<p>Provider agent Information is optional. If you wish to include provider agent information with your application, please click the checkbox and enter the required information. If you uncheck the checkbox, any data entered will be removed.</p> <p><input type="checkbox"/> Does account belong to a provider agent (billing agent)?</p>	
Financial Institution Information	
<p>*Financial Institution Routing Number <input type="text"/></p> <p>*Type of Account at Financial Institution <input type="text" value="v"/></p> <p>*Provider's Account Number with Financial Institution <input type="text"/></p> <p>Provider Tax Identification Number (TIN) *****XXXX</p> <p>Provider National Provider Identifier (NPI) XXXXXXXXXXX</p>	
Reason for Submission	
<p>Reason For Submission New EFT</p>	
<input type="button" value="Submit"/> <input type="button" value="Cancel"/>	

Language Changes

To add or remove languages that a service location is able to interpret for non-English-speaking patients, including American Sign Language (ASL) interpretation, select the **Language Changes** link on the *Provider Maintenance* page of the Portal and make changes as instructed.

Figure 18 – Provider Maintenance: Languages

Electronic Remittance Advice Changes

To sign up to receive electronic remittance advance (ERA) as an 835 transaction, cancel receipt of 835 transactions, or make related changes, providers must be registered Portal users. From the *Provider Maintenance* page, select the **ERA Changes** link and enter information as instructed.

Figure 19 – Provider Maintenance: ERA Information

Other Information Changes (Other IHCP Program Participation)

IHCP providers can update their enrollment to add or remove participation in the 590 Program, PASRR, or MRT programs.

- To make these updates on the Portal, select the **Other Information Changes** link from the *Provider Maintenance* page and make changes as instructed (see Figure 20).
- To make the changes by mail, submit the appropriate IHCP provider packet completed as follows:
 - Select **Profile Update** in the *Type of Request* section (in Schedule A).
 - Complete the *Provider Information* section (in Schedule A).
 - Go to the *Other IHCP Program Participation* section (in Schedule B) and select the appropriate option.

Not all options are available to all provider types, and additional documentation may be required. See the [*Provider Enrollment in the Medical Review Team Program*](#) and the [*Preadmission Screening and Resident Review Level II Provider Enrollment*](#) sections for more information.

Figure 20 – Provider Maintenance: Other Information

Provider Maintenance: Other Information ?
<p>You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.</p> <p>* Indicates a required field.</p>
<p>Managed Care Program Provider</p> <p>After enrolling as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities (MCEs). Please see the <i>Hoosier Healthwise MCEs</i> and <i>Healthy Indiana Plan MCEs</i> sections of the IHCP Quick Reference Guide at indianamedicaid.com for contact information.</p>
<p>Other IHCP Program Participation</p> <p>This enrollment is to serve Medicaid members and is the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this enrollment considered as an enrollment as a provider in other IHCP programs, serving particular member populations. Please indicate if you are interested in enrolling as a provider in one or more of the following programs:</p> <p>The 590 Program is a State medical assistance program providing reimbursement for medically necessary covered medical services provided at offsite facilities to individuals who reside in State institutions.</p> <p>*Participate in the 590 Program? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>The Pre-Admission Screening Resident Review (PASRR) is a federally mandated screening and evaluation process. The process assesses people with mental illnesses or developmental disabilities who are being considered for nursing facility placement or nursing facility residents that have a significant change in their physical or mental condition. Diagnostic and Evaluation (D&E) teams must be contracted and approved by the Indiana Division of Disability and Rehabilitative Services (DDRS) and the Bureau of Developmental Disability Services (BDDS). Community Mental Health Centers (CMHCs) must be contracted and approved by the Indiana Division of Mental Health and Addiction (DMHA). If you are a D&E team or CMHC, please include the approval letter as an attachment.</p> <p>*Contracted to provide PASRR service? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>The Medical Review Program provides determination of an applicant's eligibility for Medicaid under the disability category. A provider enrolled in the Medical Review Program is authorized to complete a medical assessment of an applicant and submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues a favorable or unfavorable eligibility decision based on medical evidence that supports whether the applicant has a significant impairment. After the documentation has been filed, the provider may submit claims to DXC Technology for payment of certain examinations and reports. Services should not be performed unless the applicant has presented the pre-Medicaid eligibility form. There are three options for participation in the Medical Review Program:</p> <p>Medical Review Program/IHCP – Providers that elect to enroll as an IHCP provider and choose to provide MRT assessment services.</p> <p>Medical Review Program Only – Providers that do not elect to enroll in the IHCP but choose to provide MRT assessment services only.</p> <p>Medical Review Program – Medical Records Only – Providers that have been requested to supply MRT medical records only and want to bill for only those services.</p> <p>*Medical Review Program Participation: <input type="text" value="None"/></p>
<p>340B Participation</p> <p>Section 340B of the <i>Veteran's Health Care Act</i> of 1992 limits the cost of covered outpatient drugs to entities such as certain federal grantees. Federally Qualified Health Centers (FQHCs), FQHC look-alikes, and qualified disproportionate share hospitals, enabling these entities to purchase drugs at discounted rates and stretch scarce federal resources. Indiana Health Coverage Programs (IHCP) policy regarding the 340B Program is as follows:</p> <p>Federal law allows eligible entities to decide if they do or do not want to service Medicaid members using 340B stock. This decision is wholly at the discretion of the entity. However, once an eligible entity makes a decision to service or not service Medicaid members with the 340B stock, the entity is "locked" into that decision and not permitted to dispense a mix of 340B and non-340B drugs to Medicaid members.</p> <p>*340B Participation <input type="radio"/> The entity wishes to serve Medicaid members using 340B stock. It will only dispense 340B stock and bill the program accordingly at its acquisition cost of the drug, plus the Medicaid dispensing fee (carve-in).</p> <p><input checked="" type="radio"/> The entity wishes to serve Medicaid members using a separate non-340B stock. It will not use 340B stock at any time. The entity will bill the program at its usual and customary (U&C) charges to Medicaid (carve-out).</p> <p>Federal law prohibits the entity from buying at 340B acquisition cost, providing 340B purchased stock to Medicaid members, and billing Medicaid at U&C rates.</p>
<p align="right"> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p>

Note: The IHCP does not cover drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies. This policy applies to the fee-for-service (FFS) pharmacy benefit. Questions regarding 340B policies of the managed care entities (MCEs) should be referred directly to the MCEs. See the [Pharmacy Services](#) module for more information.

Rendering Provider Changes

Group practices must submit enrollment applications and updates for their rendering providers. Groups report changes to their rendering providers' status in addition to requests to enroll new rendering members. A current and active license is required for all rendering providers. The group must submit documentation that shows participation in either program for their rendering providers that apply for enrollment in the IHCP.

The IHCP policy requires rendering providers to be linked to each specific group service location where they render services. DXC links new rendering providers to the appropriate service locations (practice sites) or terminates linkage when requested. If a rendering provider's services are billed for a service location to which the provider is not linked, the RA for the claim will indicate EOB 1010 – *Rendering provider is not an eligible member of billing group or the group provider number is reported as rendering provider. Please verify provider and resubmit.* These claims will be systematically denied and providers will need to correct the linkage and resubmit the claim. Group providers should review their provider profiles to ensure that each group location has the correct rendering providers linked with accurate effective and end dates.

Rendering provider changes can be made on the Portal or by mail. Only registered group providers (or their authorized delegates) can access and make changes to the *Provider Maintenance: Rendering Providers* page.

Add Rendering Providers to a Group

Group providers must ensure that rendering providers are linked to each service location where they render services for the group practice:

- To add a linkage via the Portal, group providers use the **Rendering Provider Changes** option on the *Provider Maintenance* page. New rendering providers must first be enrolled in the IHCP before they can be linked to a group on the Portal.
- To add a linkage via mail, group providers must submit the [*IHCP Rendering Provider Enrollment and Profile Maintenance Packet*](#). Group providers may use this form to add a newly enrolling or currently enrolled rendering provider to their service locations. When adding new rendering providers to a group, the rendering provider's start date at the service location is indicated on Schedule B of the packet. Requests to enroll group members must be signed by an individual identified in section C.1 or C.3 of Schedule C in the group's packet.

Portal Instructions for Linking Rendering Providers to Group Service Locations

Only rendering providers that are already actively enrolled in the IHCP can be added (linked) to the group service location. If a group provider wants to add a rendering provider that is not yet enrolled in the IHCP, the group provider must enroll the rendering provider through the Provider Enrollment function on the Portal.

An IHCP-enrolled rendering provider can be linked to multiple service locations in a single Portal transaction. The following parameters apply:

- The user submitting the transaction must be an authorized delegate for provider maintenance tasks on the Portal accounts for each of the affected group service locations included in the transaction.
- Rendering linkages in a single transaction may be to group locations operating under different tax IDs. A separate [*IHCP Rendering Provider Agreement and Attestation Form*](#) is required to support the linkages of **each individual rendering practitioner** to the group service locations operating under **each unique group tax ID** included in the transaction.
- The effective date of the linkages for an individual rendering practitioner must be the same for each service location when they are submitted in a single transaction. Linkages for that practitioner that have different effective dates will require separate transactions. If more than one practitioner is linked in a single transaction, each additional practitioner can have a unique effective date associated with their linkages.

To add (link) an enrolled rendering provider to a group service location, follow these steps:

1. At the *Provider Maintenance: Rendering Providers* panel (Figure 21), enter an effective date in the Rendering Linkage Effective Date field.
2. Enter either an IHCP Provider ID or NPI for the rendering provider being added. (The Provider ID is preferred, but NPI is also an option. Waiver providers must enter a Provider ID and not an NPI.)
3. Select the **I Accept** check box to confirm that a signed *IHCP Rendering Provider Agreement and Attestation Form* will be uploaded or sent by mail (as described in steps 11–15).
4. Select the **Rendering Provider Agreement and Attestation Form** link and print the form.
5. Click **Add**.
6. To add that same rendering provider to another service location for the group, click the “+” button next to the newly added rendering provider’s NPI.

Figure 21 – Provider Maintenance: Rendering Providers

Provider Maintenance: Rendering Providers

Rendering Providers

If you are adding new rendering providers, you will be required to supply a Rendering Agreement and Attestation Form for each. You are allowed to upload up to 10 Rendering Agreement and Attestation Forms. Any additional forms must be sent by mail along with the ATN coversheet presented at the end of this process.

* Indicates a required field.

* Rendering Linkage Effective Date

* Either a Provider ID or NPI is required.

Only currently enrolled rendering providers can be added to this group provider.

NPI Provider ID

* I accept ☐

I attest that a signed Rendering Provider Agreement and Attestation Form will be sent by mail along with the coversheet furnished at the end of this application submission. Please use the link below to obtain a copy of the most current Rendering Provider Agreement and Attestation Form. Both the group's owner or authorized official and the rendering provider must sign this form.

Attach one Agreement per Group Tax ID for each rendering provider

[Rendering Provider Agreement and Attestation Form](#)

Only the newly added rendering provider can be expanded to add the additional groups.

Click the Remove link to remove the row.

	NPI	Provider ID	Name	Rendering Linkage Effective Date	Action
			Rendering Provider 1	09/01/2007	Remove
			Rendering Provider 2	10/12/2017	Remove
<input type="checkbox"/>			Rendering Provider 3	05/25/2018	Remove

7. Complete the *Additional Group Locations* panel with the NPI or Provider ID, taxonomy, and 9-digit ZIP Code for the additional group location to which the rendering provider should be linked, and click **Add**. The panel will populate, showing the group service location’s linkage entered.

Figure 22 – Additional Group Locations

NPI	Provider ID	Name	Address	Rendering Linkage Effective Date	Action
		GROUP B LOCATION		05/25/2018	Remove

Click to collapse.

Provider ID:
 NPI:

Taxonomy Code:

Zip Code (State):

8. Repeat steps 6 and 7 for each additional group service location to which that same rendering provider should be linked.
9. If you have more rendering providers to add to this group service location, complete steps 1 through 8 for each rendering provider. **Do not click Submit** until you have added all rendering providers that you intend to add during this session.

Note: The session is limited to 10 uploaded Rendering Provider Agreement and Attestation forms. If you are adding more than 10 rendering providers at a time, you will need to start a new session to add each set of up to 10 providers and upload the corresponding provider agreement and attestation forms or, alternatively, you can add all the providers in a single session and send the additional agreements by mail.

10. After you finish adding all rendering providers and linkages, click **Submit**.
11. At the *Provider Maintenance: Application Attachments* page ([Figure 23](#)), in the Attachment Type drop-down menu, select the **Rendering Provider Agreement and Attestation Form** option for one of the rendering providers added. Each form is identified with an NPI or Provider ID that was entered in step 2.

Figure 23 – Provider Maintenance: Application Attachments

Provider Maintenance: Application Attachments

* Indicates a required field.

Supporting Documentation

The following attachment action needs to be taken to complete the change request process. To submit attachments, please follow the instructions in the Attachments panel below.

Double-check that all required supporting documentation, is included as an attachment to the packet. **Required documentation** is listed on the [Provider Type and Specialty Matrix](#).

Note: If you choose to "Upload" attachments by "File Transfer", a maximum of 10 MBs of information can be uploaded. Any additional documents above the 10 MB limit, must be sent via mail by selecting the "By Mail" **Transmission Method**.

Attachments

To add an attachment, complete the required fields and click the **Add** button.

Use the 'Other' selection to upload attachments not in the list.

Click the **Remove** link to remove the row.

#	Transmission Method	File	Attachment Type	Action
<input type="checkbox"/> Click to collapse.				
	<p>*Attachment Type</p> <p>*Transmission Method</p> <p>*Upload File</p>	<div> <div>Rendering Provider Agreement and Attestation Form - xxxxxxxxxx</div> <div>Other</div> </div> <div> <input type="text"/> <input type="button" value="Browse..."/> </div>		
<p>The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png</p>				
<div> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </div>				
<div> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </div>				

12. Complete the required *IHCP Rendering Provider Agreement and Attestation Form* (printed in step 4) for the rendering provider. Both the group provider (or authorized official) and the rendering provider must sign the form.

Note: A signed Rendering Provider Agreement and Attestation Form must be submitted for every rendering provider that was added to a group service location. A single agreement/attestation form can be used to support the linkages of a single practitioner to multiple group service locations operating under a single group tax ID; however, separate agreement/attestation forms are required to support linkages of that same practitioner to group locations operating under different group tax IDs.

The agreement/attestation forms may be uploaded to the Provider Maintenance: Application Attachments page or submitted via mail. Each Portal session is limited to 10 uploaded Rendering Provider Agreement and Attestation Forms. If you are adding more than 10 rendering providers in one session, you will need to mail the additional agreements with the cover sheet provided at the end of the linkage process.

13. In the Transmission Method drop-down menu, select the method that will be used to submit the form:
- Select **FT-File Transfer** if uploading the form electronically. The signed form must be digitized and then attached using the Upload File field.
 - Select **BM-By Mail** if sending the form by mail. The signed form must then be sent by mail along with the agreement and attestation forms for all other providers added during this session and the coversheet, printed in step 17.
14. Click **Add** to finalize the process for the selected attachment.
15. Repeat steps 11–14 for all rendering providers added during this session.
16. Click **Submit** to complete the transaction.

Note: The transaction creates only one automated tracking number (ATN), regardless of how many rendering provider linkages were requested.

17. If BM-By Mail was selected for any of the agreement and attestation forms, **select the option to print the coversheet and follow the instructions to send the signed forms and the coversheet to the address listed.**

Remove Rendering Provider from Group Service Location

When rendering providers leave a group, the group provider must remove the rendering provider from the group, either by using the **Rendering Provider Changes** option on the *Provider Maintenance* page of the Portal or by submitting an [IHCP Rendering Provider Enrollment and Profile Maintenance Packet](#) or an [IHCP Provider Disenrollment Form](#) to request that the linkage be deactivated. The deactivation request should give the date of termination from the service location (must be current or past date) for the rendering provider. The form must be signed.

Portal Instructions for Removing Rendering Providers from Group Service Locations

To remove a rendering provider from the group service location via the Portal, follow these steps:

- At the bottom of the *Provider Maintenance: Rendering Providers* panel (Figure 24), click the **Remove** link for each provider you wish to remove (unlink from the group).

Note: If the rendering provider is currently enrolled as a PMP, the provider must first contact the appropriate MCE to change his or her PMP status before the Remove option will appear on this screen.

- Click **Submit**.

Figure 24 – Provider Maintenance: Rendering Providers – Bottom Half

Click the **Remove** link to remove the row.

				Total Records: 11
NPI	Provider ID	Name	Rendering Linkage Effective Date	Action
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	04/01/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	04/06/2015	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	01/26/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	01/26/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	01/26/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	01/12/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	04/06/2015	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	05/02/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	01/26/2011	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	04/06/2015	Remove
XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX XXXXX	01/26/2011	Remove

Provider Identification Changes

Providers are required to keep their name, certifications, and other identifying information current in their IHCP provider profiles. The **Provider Identification Changes** link on the *Provider Maintenance* page of the Portal enables providers to make changes to any of the following:

- Provider legal name or doing business as (DBA) name (not related to a CHOW)
- Organizational structure
- NPI
- Taxonomy
- License and certification information
- Medicare number
- Patient population
- CLIA certification
- Drug Enforcement Administration (DEA) number

These changes can also be made by mail, using the appropriate IHCP provider packet or one of the following update forms:

- [*IHCP Provider Name and Address Maintenance Form*](#)
- [*IHCP Provider Enrollment Recertification of Licenses and Certifications Form*](#)
- [*IHCP Provider Medicare Number Maintenance Form*](#)
- [*IHCP Provider CLIA Certification Maintenance Form*](#)

When reporting a change of legal name or DBA name, providers must submit a W-9 that shows the new information. For name changes related to a CHOW, see the [*Change of Ownership*](#) section.

For recertification updates, the appropriate certificate, approval letter or notice, proof of insurance, or license to extend their eligibility must be submitted along with the update. For more information about license and certification requirements, see the [*Maintaining Licensure and Certification*](#) section.

Figure 25 – Provider Maintenance: Provider Identification (Top Half)

Provider Maintenance: Provider Identification ?					
<p>You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.</p> <p>* Indicates a required field.</p>					
Provider Legal Name					
<p>WARNING - The legal name and provider federal tax identification number (TIN) must match the information on the W-9. The provider legal name is considered to be the entity maintaining ownership of the named business. The legal name must match the information registered with the Secretary of State, if registered. If this Legal Name and Tax Identification Number is associated with more than one provider ID, the legal name change will be applied to all provider IDs associated with this Tax ID (W-9).</p> <p>*Is the change in Legal Name a result of a Change of Ownership? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>*Provider Legal Name <input type="text" value="XXXXXXXXXXXX"/></p> <p>The doing business as (DBA) name identifies the site where members obtain services and that is owned or rented by the provider. The DBA name must match the business name on the W-9.</p> <p>Doing Business As Name <input type="text"/></p>					
Organizational Structure					
<ul style="list-style-type: none"> If your business is chain affiliated, the information about the company or organization must be included in the disclosure information. If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information. Entities doing business in Indiana, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to in.gov/sos to find out how to complete the registration process. <p>*Organization Type <input type="text" value="Individual/Sole Proprietor"/></p> <p>Entities doing business in state, except for information associates such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to Click Here to find out how to complete the registration process.</p> <p>Registered with Indiana Secretary of State <input checked="" type="checkbox"/> Business Start Date <input type="text" value="07/25/2017"/> </p> <p>Incorporated <input type="checkbox"/> Incorporation Date <input type="text"/> </p> <p>Chain Affiliated <input type="checkbox"/></p> <p>Operated by Management Company <input type="checkbox"/></p>					
Provider Identification					
<p>National Provider Identifier (NPI) is a unique identification number for healthcare providers.</p> <p>... NPI subpart information</p> <p>*NPI <input type="text" value="XXXXXXXXXX"/></p>					
Taxonomy Information					
<p>A taxonomy code identifies a healthcare provider type and specialty; it is not a unique physician identification number (UPIN), a Medicare provider number, or an IHCP provider number. The full taxonomy code set can be found at wpc-edi.com under <i>Reference</i>. The taxonomy requested is the taxonomy associated with the provider's NPI.</p> <p>Please include all taxonomy codes that reflect the services to be provided at this service location.</p> <p>* At least one taxonomy code must be entered.</p> <table border="1"> <thead> <tr> <th>Taxonomy</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>207Q00000X-Family Medicine</td> <td>Remove</td> </tr> </tbody> </table> <p> Click to add taxonomy.</p>		Taxonomy	Action	207Q00000X-Family Medicine	Remove
Taxonomy	Action				
207Q00000X-Family Medicine	Remove				

Figure 26 – Provider Maintenance: Provider Identification (Bottom Half)

License Information							
* At least one license must be entered.							
	License Number	Name as it appears on the License	Effective Date	Expiration Date	Issuing State	License Type	Action
<input type="checkbox"/>	XXXXXXXXXX	XXXXXXXX XXXXX	01/01/2015	12/12/2299	Indiana	Other	Remove
<input type="checkbox"/> Click to add license information.							
Medicare Participation							
If you are a Medicare provider, you must provide your Medicare provider numbers.							
	Medicare Number						Action
<input type="checkbox"/>	XXXXXXA						Remove
<input type="checkbox"/> Click to add Medicare number.							
Patient Population Information							
Enter the anticipated percentage of your patient population with the following payment sources. The sum of the entered values must equal 100.							
*Medicaid <input type="text" value="10"/>		*Self-Pay <input type="text" value="80"/>		*Medicare <input type="text" value="5"/>		*Other Insurance <input type="text" value="5"/>	
CLIA Certification							
If your facility includes a laboratory, document your Clinical Laboratory Improvement Amendment (CLIA) Certificate information in this section. A copy of the CLIA certificate must be included as an attachment to the packet. A certificate is required for each location where laboratory testing is performed unless the lab qualifies for one of the CMS exemptions listed below: Laboratories that are not at a fixed location (that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations) may be covered under the certificate of the designated primary site or home base, using its address. Not-for-profit or Federal, State, or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) might have multiple CLIA certificates that apply to the service location; include all applicable CLIA certificates with the enrollment packet. Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction might have a single or multiple CLIA certificates for the laboratory sites within the same physical location or street address. Include all applicable CLIA certificates with the enrollment packet.							
	CLIA Number	Effective Date	Expiration Date	CLIA Certification	Action		
<input type="checkbox"/> Click to collapse.							
<div> <div>CLIA Number <input type="text"/></div> <div>Effective Date <input type="text"/></div> <div>Expiration Date <input type="text"/></div> <div>CLIA Certification <input type="text"/></div> </div> <div> <input type="button" value="Add"/> <input type="button" value="Reset"/> </div>							
Drug Enforcement Administration (DEA) Number							
DEA # <input type="text"/> Effective Date <input type="text"/> End Date <input type="text"/>							
<input type="button" value="Submit"/> <input type="button" value="Cancel"/>							

Disclosure Changes

To report new or departing owners, board members, or managers or to update information for disclosed corporations and subcontractors, select the **Disclosure Changes** link on the *Provider Maintenance* page and make changes as instructed. Do not use the Disclosure Changes link to report CHOW information.

To submit disclosure changes by mail, use the appropriate IHCP provider packet.

Figure 27 – Provider Maintenance: Disclosures

Provider Maintenance: Disclosures					
<p>*Is the change in Disclosures related to a Change of Ownership? <input type="radio"/> Yes <input checked="" type="radio"/> No</p>					
Fingerprint Background Check Information					
<p>Fingerprinting and Criminal Background Check Providers assigned to the high-risk category are required to have a national fingerprint-based criminal background check. (Please refer to the IHCP Provider Enrollment Risk Category and Application Fee Matrix to determine if your provider type is high-risk.)</p> <p>This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity. The requirement also applies to individual practitioners who have been assigned to the high-risk category.</p> <p>Refer to the indianamedicaid.com web site for additional information about Fingerprinting and Criminal Background Check.</p>					
Individuals with an Ownership or Control Interest and Managing Individuals					
<p>Please list all individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider entity.</p> <p>Include each person's name, address, date of birth (DOB), and Social Security number (SSN). Also indicate the title (e.g., chief executive officer, owner, board member) and if an owner, the percent of ownership.</p> <p>Managing Individuals List all agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals.</p> <ul style="list-style-type: none"> An agent is any person who has express or implied authority to obligate or act on behalf of the entity. An officer is any person whose position is listed as an officer in the provider's articles or incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body. A director is a member of the provider's board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word director in his or her job title, such as director of operations or departmental director. A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity. 					
* Indicates a required field.					
	Name of individual	Disclosure Type	SSN	Birth Date	Action
<input type="checkbox"/>	XXXXXXXX XXXXX	Managing Individuals, Ownership and Control	*****XXXX	XX/XX/XXXX	Remove
<input type="button" value="Click to add disclosed entity"/>					
Corporations with an Ownership or Control Interest					
<p>If a corporation, please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, including P.O. Box address(es).</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.</p>					
	Name of Corporation	TIN	Action		
<input type="button" value="Click to add disclosed entity"/>					
Subcontractors					
<p>Subcontractors - Please list all subcontractors in which the applicant has a 5% or more ownership or control interest, include any subcontractor and their address and Tax Identification Number (TIN).</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.</p>					
	Name of subcontractor	Street Address	City, State, Postal Code	TIN	Action
<input type="button" value="Click to add disclosed entity"/>					
<div> <input type="button" value="Continue"/> <input type="button" value="Cancel"/> </div>					

Change of Ownership

All providers must report any change in ownership (CHOW), including but not limited to **any change** in direct or indirect ownership or control interest, merger, corporate reorganization, change in legal or DBA name, or change in federal tax ID.

To report a CHOW, providers must submit a new enrollment application for each service location. Providers are encouraged to use the Portal to perform CHOW enrollments. The Portal provides step-by-step instructions for enrolling as a CHOW.

The new ownership entity must submit the following:

- A Portal enrollment application with **Change of Ownership** selected as the enrollment request type

Or

A completed *IHCP Provider Enrollment and Profile Maintenance Packet* with **Change of Ownership** selected as the type of request (in Schedule A), including a signed *IHCP Provider Agreement* **and** an *IHCP Provider Change of Ownership Addendum*

- A W-9
- A copy of the purchase agreement or bill of sale
- Appropriate licensure, where applicable
- Any other appropriate forms or attachments necessary for enrollment

*Note: Clicking the **Change of Ownership (CHOW) Overview** link on the Provider Maintenance page of the Portal displays information about when to report a change of ownership and how to do it. CHOWs cannot be reported via the Provider Maintenance option. Instead, to report a CHOW, log out of the Portal and select the Provider Enrollment link from the Portal home page.*

Extended care facilities must follow a different process to perform a CHOW on the Portal, as described in the following section.

CHOWs for Extended Care Facilities

According to *Indiana Administrative Code (IAC) 405 IAC 1-20*, the provider assuming ownership of an extended care facility is required to take over the seller's Medicaid enrollment and Provider ID when undergoing a CHOW. This requirement applies to IHCP provider type 03 – *Extended Care Facility* providers with any of the following specialties:

- 030 – *Nursing Facility*
- 031 – *Intermediate Care Facility for Individuals with Intellectual Disabilities*
- 032 – *Pediatric Nursing Facility*
- 033 – *Residential Care Facility*

Additionally, 405 IAC 1-20 requires these providers to notify the FSSA or the fiscal agent no less than 45 business days **before** the anticipated effective date of sale or lease agreement that a change of ownership may take place. Notification must be submitted in writing, and must include the following information:

- A copy of the agreement of sale or transfer
- The expected date of the sale or transfer
- If applicable, the name of any individual who meets at least one of these qualifications:
 - Has an ownership or control interest
 - Is a managing employee
 - Is an agent of the transferor (selling provider) who will also hold an ownership or control interest, be a managing employee, or be an agent of the transferee (purchasing provider).

The transferee must submit an IHCP provider packet (along with required documentation) for amendment to the transferor's provider agreement no less than 45 days before the effective date of the transfer, or receive a waiver from the FSSA if the transferee is unable to comply with the 45-day notice provision.

LTC providers must mail the documentation to the following address:

**IHCP Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263**

Portal Instructions for an Extended Care Facility CHOW

Extended care facility providers are encouraged to submit CHOW applications and the required supporting documentation through the Portal as described in this section. To use this option, the selling provider must have a registered account on the Portal.

To submit an extended care facility CHOW via the Portal, follow these steps:

1. The purchaser must log in to the Portal using the registered seller's security credentials and click the **Extended Care Facility CHOW** link on the *My Home* page.

Note: After the CHOW is processed, the new owner can establish new security credentials and change access delegations for the provider's Portal account as appropriate.

Figure 28 – Extended Care Facility CHOW Link on My Home Page



2. The *Provider Enrollment* page appears, allowing the purchaser to start a new CHOW application, resume an unfinished CHOW application, or check the status of a previously submitted CHOW application.

Figure 29 – Extended Care Facility CHOW Application Links on the Portal Provider Enrollment Page



3. To complete a new Extended Care Facility CHOW application, the purchaser must enter the new owner's tax ID, new ownership disclosure information, and any other pertinent information related to the change of ownership. The supporting documentation required as attachments to the CHOW application include:
 - W-9 form
 - Copy of the bill of sale

If the previous owner was set up to receive the electronic remittance advice (ERA) 835 transactions, and the trading partner ID that will be receiving the ERA 835 is not changing, then no new trading partner information from the new owner is needed. However, if the trading partner receiving the ERA 835 is changing, then the new owner must access the *Provider Maintenance/ERA Information* page on the Portal and change the trading partner ID on that page.

To change the trading partner ID, follow these steps:

1. From the *My Home* page in the Portal, click the **Provider Maintenance** link.
2. On the *Provider Maintenance: Instructions* page, click the **ERA Changes** link.
3. Enter the new trading partner ID in the New ERA 835 Information section of the *Provider Maintenance: ERA Information* page.
4. Choose **Change ERA** from the Reason For Submission drop-down menu.
5. Type in an authorized electronic signature.
6. Click **Submit** at the bottom of the page to submit the change.

Figure 30 – Fields for Changing the Trading Partner ID on the Provider Maintenance/ERA Information Page

Provider Maintenance: ERA Information	
<p>Providers that would like to receive claim payment information using electronic remittance advice (ERA/835) transactions should enter all the fields in the below panel.</p> <p>If ERAs/835s are to be electronically exchanged, then an account should be established using this page within the maintenance application.</p> <p>* Indicates a required field.</p>	
Current ERA/835 Information	
Trading Partner ID	R475
Authorized Signature	_
Provider Identifiers Information	
Provider Name	OLDER AMERICANS SERVICE CORP
Provider Federal Tax Identification Number(TIN) or Employer Identification Number(EIN)	
Provider National Provider Identifier (NPI)	_
New ERA/835 Information	
Trading Partner ID	<input type="text"/>
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier):	
Provider Federal Tax Identification Number(TIN) or Employer Identification Number(EIN)	
Provider National Provider Identifier (NPI)	_
Submission Information	
*Reason For Submission	<div> <div>Cancel ERA</div> <div>Change ERA</div> </div>
*Authorized Signature	<input type="text"/>
Printed name of Person submitting Enrollment.	
<div>Submit</div> <div>Cancel</div>	

Revalidation

Federal regulations require all providers participating in the IHCP to revalidate their enrollment at least every 5 years. Durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialties revalidate every 3 years. Federal regulations do not permit the IHCP to reimburse for services rendered after a provider's enrollment is end dated due to failure to revalidate by the specified date.

Providers receive written notification of their revalidation deadline. In addition to the written notification, providers that are registered with the Portal also receive notice on their Portal account when a revalidation is due.

Note: Providers are encouraged to use the [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers for revalidation processes. The Portal allows for electronic signatures.

Revalidation of an enrollment requires use of the Revalidation option in the Portal or submission by mail of a new IHCP provider packet. For designated provider types, an application fee is also required for revalidation, as described in the [Application Fee](#) section. All revalidations require screening activities associated with the provider's assigned risk level, such as site surveys or criminal background checks, as described in the [Risk Category Requirements](#) section.

Note: Providers that do not intend to revalidate their enrollment should complete the disenrollment process on the Portal or submit the [IHCP Provider Disenrollment Form](#) available at in.gov/medicaid/providers, which allows the IHCP to complete a voluntary disenrollment and keep its provider database up-to-date.

The following information is intended to help providers better understand revalidation requirements:

- Providers are required to revalidate their enrollment with Medicare and the IHCP separately. Revalidating with Medicare will not revalidate a provider's IHCP enrollment.
- Revalidation is a reenrollment process, not an update process. When revalidating enrollment online, providers choose the Revalidation icon on the Portal and follow the prompts to complete the pages required. Providers will be required to reenter some of the information that previously had been prepopulated on revalidation submissions. Providers should be prepared to provide the following information for enrollment revalidations:
 - All providers will be required to reenter all disclosure information at the time of revalidation.
 - All group providers will be required to verify every rendering provider's status with the group and remove any rendering providers no longer active at the service location that is revalidating.
 - All group providers will be required to include a newly signed *Rendering Provider Agreement* for each rendering provider that remains active at the service location that is revalidating.

Note: Since this module's policies and procedures effective date, the time frame for receiving the signed application submission was extended from 30 days to 90 days from the date the IHCP Provider Agreement or the IHCP Rendering Provider Agreement is signed. Applications with provider agreements that are received beyond the 90 days will not be accepted and a new agreement will need to be submitted with updated signatures.

- When revalidating enrollment by mail, providers must indicate revalidation by checking the Revalidate Enrollment box on the IHCP provider packet, and then complete *all applicable fields*, not just those fields with new information. If a packet is submitted with only "Revalidate Enrollment" marked in item 1, and the rest of the packet blank, or with only some fields completed, the packet will be considered incomplete. Incomplete packets will be returned to providers with a request that they be resubmitted with the missing information added.

- A properly completed W-9 must be submitted with the Portal revalidation or IHCP provider packet. Discrepancies on the W-9 will result in the application being returned to the provider, delaying revalidation.
- Disclosures on the application must contain complete and thorough information about all disclosed individuals, including name, Social Security number, and date of birth. The application must contain a **complete** list of disclosures, not just those individuals added or deleted from a prior disclosure.
- When revalidating by mail, using the IHCP group provider enrollment packet, group providers should disregard the *IHCP Rendering Provider Enrollment and Maintenance Packet* portion of the packet. Instead, as an attachment to the group's enrollment packet, a group should include a list of rendering providers linked to the service location at the time of revalidation and a signed rendering provider agreement for each of the rendering providers linked to the group. The list of rendering providers must include the information outlined in the instructions on page 1 of the IHCP group provider enrollment packet. Any new rendering provider must first enroll and then be linked to the group.
- A revalidation notice is mailed to providers 90 days before their revalidation due date, using the mail-to address on file. (Providers registered on the Portal will also have a Revalidation icon displayed on their Portal account 90 days before their revalidation is due.) A second notification letter is mailed 60 days before the revalidation due date. Providers with multiple service locations (practice sites) must revalidate each location individually and will receive a separate letter for each location.
 - Providers should not revalidate until they see the revalidation icon on the Portal or receive their notification by mail.
 - Providers that fail to submit properly completed revalidation paperwork by their revalidation due date will be disenrolled. After being disenrolled, the provider will need to complete the provider enrollment process on the Portal or submit a new *IHCP Enrollment and Profile Maintenance Packet* to reenroll with the IHCP. Disenrollment with subsequent reenrollment may result in a gap in the provider's eligibility.

Note: Providers should not take any steps to revalidate until they see the revalidation icon on their Portal account or receive their notification letters. It is important that providers keep their address information up to date to ensure that they receive this notice. Failure to submit the required documentation prior to the deadline will interrupt the ability to have claims paid.

Checking Provider Revalidation Status

The Portal allows users to check the status of their revalidation online.

Portal users can select the **Enrollment/Revalidation Status** link on the *My Home* page and enter the tracking number and the EIN or SSN associated with the revalidation application to monitor the status of the revalidation.

Figure 31 – Provider Enrollment/Revalidation Status

Provider Enrollment / Revalidation - Status [Back to My Home](#) ?

Enter your assigned Tracking number and Federal Tax Identification Number (TIN or EIN) associated with your enrollment or revalidation application to verify its current status. For any further queries, please contact Provider Enrollment at 1-800-577-1278 (Option 3).
* Indicates a required field.

*Tracking Number *Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN)

Provider Deactivation and Disenrollment

Providers may voluntarily end their IHCP enrollment at any time. To complete a voluntary deactivation request, providers must use the Disenroll link on the *My Home* page of the Portal or submit an [IHCP Provider Disenrollment Form](#). If “Other” is selected as the reason for deactivation, providers must clearly state the reason for the deactivation request. The deactivation date is the date the disenrollment form is signed, unless otherwise requested.

It is recommended that providers update their mailing information if an address changes upon disenrollment – for example, if the provider is disenrolling due to a move to another state. The change ensures that payments, resulting from claim adjustments after the provider terminates, go to the appropriate address. Address updates are submitted on the *Provider Maintenance* page of the Portal or by mail, using the [IHCP Provider Name and Address Maintenance Form](#). See the [Address Changes](#) sections for instructions.

Disenroll through the Portal

Requests for disenrollment from the IHCP ensure that the provider’s profile history is accurately maintained.

Note: Providers enrolled as a PMP with an MCE must contact the MCE first to begin the disenrollment process. See the [Managed Care Disenrollment](#) section.

If enrolled as a waiver provider, the provider must contact the State waiver agency first to begin the disenrollment process.

A provider can voluntarily disenroll from the IHCP through the Portal. An assigned delegate authorized for this function can also disenroll the provider using the Portal.

1. Click the **Disenroll Provider** link on the Portal’s *My Home* page.
2. Complete the required fields.
3. Click **Disenroll**.
4. After the Provider Enrollment Unit processes the disenrollment, a notification will be sent to the provider to verify disenrollment from the IHCP.

Figure 32 – Disenroll Provider

Disenroll Provider [Back to My Home](#)

* Indicates a required field.

This utility allows for Providers to voluntarily disenroll from the IHCP.

Requesting Provider Information

Provider ID: XXXXXXXXXX ID Type: NPI Name: XXXXXXXXXX XXXXXXXX

*Requested Disenroll Date:

*Disenroll Reason:

*Contact Name:

*Contact Telephone:

*Contact Email:

After the DXC Technology Provider Enrollment Unit processes your disenrollment form, they will notify you.

By entering my full name in the space provided below and transmitting this form electronically, I state that, I am the person whom I represent myself to be herein, and I acknowledge that I have read and understand the User Agreement and agree to the terms and conditions as described about the role that I will perform.

*Please sign by typing your full name here:

Disenroll **Cancel**

Managed Care Disenrollment

Deactivation or termination from the IHCP, whether voluntary or involuntary, results in the provider's immediate disenrollment from HIP, Hoosier Care Connect, and Hoosier Healthwise.

Providers that want to disenroll from only the HIP, Hoosier Care Connect, or Hoosier Healthwise components of the IHCP must contact the contracting MCE. If the Provider Enrollment Unit receives the request before the PMP disenrollment, Provider Enrollment employees coordinate with the MCEs. Providers can contact their MCE for additional details about disenrollment from a health plan program.

Involuntary Termination or Deactivation

The FSSA or its fiscal agent may deactivate or terminate a provider's IHCP enrollment for the following reasons:

- License or certification expiration, suspension, or revocation
- Conviction of Medicaid or Medicare fraud
- Violation of federal or state statutes or regulations
- Name matched against the following:
 - U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) exclusion list
 - System for Award Management (SAM) exclusion list
 - TIBCO MFT (Managed File Transfer)
- Breach of any provisions in the *IHCP Provider Agreement*
- Returned mail
- No claim activity for more than 18 months

Payment for Services after Deactivation or Termination

Providers have up to 1 year from a date of service to file claims for service dates that fall within their eligibility period.

Under *IC 12-15-22-4*, following their deactivation or termination of participation in the IHCP, providers are no longer eligible for payment for services rendered for dates of service after the date of deactivation or termination.

Appeal Process

Under *IC 4-21.5-3-7* and *405 IAC 1-1.4-12*, providers have the right to appeal deactivation or termination action. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.

Send the appeal to the following address:

**MS07
Secretary, Indiana Family and Social Services Administration
c/o Gwen Killmer, Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204**

Providers that elect to appeal a determination must also file a statement of issues within 45 calendar days after receipt of notice of the determination. The statement of issues must conform to *405 IAC 1-1.4-12* and *IC 4-21.5-3* and be sent to the same address as the appeal request.

Section 5: Ordering, Prescribing, or Referring Providers (Type 50)

For Medicaid to reimburse for services or medical supplies that are provided as a result of a provider's order, prescription, or referral, federal regulations (42 CFR Parts 405, 447, 455, 457, and 498) require that the ordering, prescribing, or referring (OPR) provider be enrolled in Medicaid. Indiana Health Coverage Providers (IHCP) providers that render services to Medicaid members must verify IHCP enrollment of the OPR provider before the service or supplies are rendered. For this verification, providers can use the [OPR Search Tool](#), accessible from the [Ordering, Prescribing, or Referring Providers](#) page at in.gov/medicaid/providers.

To address this requirement and to encourage nonenrolled practitioners to enroll in the IHCP, a category of enrollment has been created for OPR providers. The OPR provider category is appropriate for practitioners who do not plan to bill the IHCP for payment of services rendered, but who may occasionally see an individual who is an IHCP member and who needs an order, prescription, or referral for additional services or supplies that will be covered by the Medicaid program.

For organizations enrolling as an OPR provider, all practitioners within the organization who might order, prescribe, or refer services or supplies for IHCP members will need to enroll separately as individual OPR providers.

Participating in the IHCP as an OPR provider allows other providers to be reimbursed for the Medicaid covered services and supplies that the OPR provider orders, prescribes, or refers for IHCP members. A simplified application process requires minimal information and time and makes participation easy.

Note: OPR providers cannot submit claims to the IHCP for payment of services rendered. If a provider wants to be able to submit claims, enrollment as another IHCP provider type is required. Providers that are already enrolled as another type of provider in the IHCP do not need to enroll as an OPR provider.

OPR Requirements

Enrollment as an OPR provider is appropriate only for providers that meet the following criteria:

- Are not enrolled in the IHCP under any other provider type
- Do not want to be enrolled in the IHCP as a billing, group, or rendering provider
- Do not plan to submit claims to the IHCP for payment of services rendered
- Have obtained a National Provider Identifier (NPI)

Enrolling as an OPR Provider

Enrollment in the IHCP as an OPR provider can be completed online or by mail.

To enroll **online**, follow these steps:

1. Go to the [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers.
2. Click the **Provider Enrollment** link.
3. Click the **Provider Enrollment Application** link.
4. Read the introductory information and then click **Continue**.

5. Select **Ordering, Prescribing, Referring (OPR)** from the Provider Category drop-down box in the Initial Enrollment Information section. This action automatically enters the OPR provider type (50) into the Provider Type field.
6. Follow instructions to complete the remainder of application.

To enroll **by mail**, follow these steps:

1. Go to the Participating as an OPR Provider section of the [Ordering, Prescribing, or Referring Providers](#) page at [in.gov/medicaid/providers](#).
2. Click the [IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet](#) link.
3. Follow instructions in the packet to enroll in the IHCP as an OPR provider.
4. The IHCP provider packet is an interactive PDF file, allowing providers to type information into the fields, save the completed file to their computer, and print the file for mailing.
5. Submit the packet using the mailing instructions in the packet.

OPR providers are not required to pay an application fee.

Updating OPR Provider Information

When an enrolled provider's information changes (for example, when license information, contact information, name, or address changes), the provider is *required* to submit updated information to the IHCP within 30 business days.

Providers are encouraged to use the **Portal** to submit updates. See the [Submitting Provider Profile Updates via the Provider Healthcare Portal](#) section for instructions.

If submitting updates **by mail**, follow these instructions:

1. Complete only the following fields of the [IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet](#):
 - Field 1 – Type of request
 - Field 5 – Name of enrolling individual or entity
 - Field 36 – Enter your NPI
 - Any other fields with information that needs to be updated
 - Fields 45–47 – Provider Signature/Attestation
2. Submit the packet using the mailing instructions in the [Submitting and Processing OPR Provider Transactions](#) section.

Converting to OPR from Rendering or to Rendering from OPR

An actively enrolled OPR provider can convert to a rendering provider, or an actively enrolled rendering provider can convert to an OPR provider, in a single Portal transaction. This process applies to conversions between these two classifications only. The provider must be a registered Portal user to perform the conversion on the Portal.

Providers can access this feature by following these steps:

1. Log in to the Portal as a registered OPR provider or as a registered rendering provider.
2. On the *My Home* page, under the Provider section, select the **Converting OPR or Rendering** link.

Figure 33 – Portal Link for Converting OPR or Rendering Provider Classifications



- On the *Provider Enrollment Conversion* panel, select **OPR or Rendering Conversion** to begin a new request.

To resume a conversion request previously started but not yet completed and submitted, select **Resume Conversion**. To view the status of a conversion request already submitted, select **Conversion Status**.

Figure 34 – Choose a Conversion Option



- When selecting the option to begin a new request or to resume a request, the *Provider Conversion: Request Information* page is displayed. Enter an effective date for the change. The effective date can be a retroactive date but not a future date.

Figure 35 – Provider Conversion: Request Information Page to Begin a Conversion Request

- Follow all prompts to enter the required enrollment data for the new classification (either OPR or rendering) and select **Confirm** on the *Summary* page to submit your request.

Note: There is no need to complete a deactivation to convert between these two provider classifications; the system will end date the old classification (either OPR or rendering) associated with the enrolled provider profile and activate the new classification. The provider's existing IHCP Provider ID will automatically be assigned to the new provider profile.

The Portal is the preferred method for converting between the OPR and rendering provider classifications. However, the IHCP will continue to accept paper transaction requests as follows:

- OPR to Rendering** – Providers are required to submit **both** an *IHCP Provider Disenrollment Form* to request deactivation as an OPR, and an *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* to request enrollment as a rendering provider, together in one submission.
- Rendering to OPR** – Providers are required to submit **both** an *IHCP Provider Disenrollment Form* to request deactivation as a rendering provider, and an *IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet* to request enrollment as an OPR provider, together in one submission.

Note: A conversion option was added to the Rendering and OPR enrollment packets after March 1, 2019. Rendering providers converting to OPR, and OPR providers converting to rendering will be able to select the conversion option in the Type of Request section of the packet that corresponds to the classification they want to convert to. All applicable sections of the packet must be completed. A disenrollment form for the classification they are converting from will not be required.

Recertifying OPR Provider Enrollment

OPR providers must maintain an active license to remain enrolled in the IHCP. Providers are not required to submit documentation to recertify their enrollment; the IHCP verifies licensing information on a monthly basis and may deactivate a provider's enrollment based on license status.

Revalidating OPR Provider Enrollment

The IHCP requires enrolled OPR providers to revalidate every 5 years based on their initial enrollment date. OPR providers will receive notification with instructions for revalidating in advance of the revalidation deadline. Notices will be sent to the mailing address on the OPR provider's enrollment file. It is important to keep address information up-to-date to ensure delivery of these notices. Providers that fail to revalidate in a timely manner will be disenrolled from the IHCP and must reenroll to participate.

OPR providers are encouraged to revalidate through the Portal using the Revalidation option. The Portal guides users through the process, and supporting documentation can be attached and submitted online. Providers must be registered on the Portal to take advantage of electronic revalidation.

OPR providers can also revalidate by mail by submitting a new *IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet*.

OPR providers are not required to pay an enrollment fee at revalidation. OPR providers are considered limited-risk providers, which simplifies the revalidation screening process.

Disenrolling as an OPR Provider

OPR providers may voluntarily disenroll from the IHCP at any time. Registered Portal users with appropriate permissions can disenroll an OPR provider from the IHCP using the **Disenroll Provider** link. See the [Disenroll through the Portal](#) section for instructions.

Note: When a provider is disenrolled from the IHCP, none of their prescriptions for Medicaid members can be filled, and medical orders may not be accepted.

Alternatively, Providers may disenroll by mail as follows:

1. Complete the [IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet](#). Detailed instructions are included in the packet. Complete only the following:
 - Field 1 – Type of request
 - Field 3 – Requested enrollment effective date
 - Field 5 – Name of enrolling individual or entity
 - Field 36 – Enter your NPI
 - Fields 45–47 – Provider Signature/Attestation
2. Submit the packet using the mailing instructions in the [Submitting and Processing OPR Provider Transactions](#) section.

Providers that are enrolled with the IHCP as an OPR provider may decide to change their enrollment status so they can bill for services rendered to their patients who are Medicaid members. To convert from OPR to a rendering provider, see the [Converting to OPR from Rendering or to Rendering from OPR](#) section. To convert from OPR to a group or billing provider, the provider is required to disenroll as an OPR provider and then enroll with the IHCP as a billing or group provider under the appropriate provider type and specialty. For more information about enrolling as another provider type, see the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers.

*Note: Currently, using the Portal to **switch** from an OPR provider to a group or billing provider type requires the provider to submit a disenroll transaction and then submit a new application as the new provider type. This process could result in an approximate 30-day gap between the two enrollments. However, if **paper forms** are used to disenroll as an OPR and to enroll as the new provider type, and the two transactions are submitted **at the same time, in the same envelope**, the new enrollment will start the day after the OPR enrollment is deactivated. Enhancements to the Portal are under way to avoid the enrollment gap when submitting these types of enrollment transactions through the Portal.*

Submitting and Processing OPR Provider Transactions

Providers are encouraged to submit enrollment applications and updates via the Portal. If submitting these transactions by mail, the following information applies.

Before mailing the provider packet, providers should make a copy of the completed packet for their records. Mail the completed packet to DXC at the following address:

IHCP Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263

Allow at least 20 business days for mailing and processing before checking the status of submission. After the transaction is processed, the Provider Enrollment Unit will notify the provider of the results:

- If the enrollment application is incomplete, the Provider Enrollment Unit will contact the provider in an attempt to complete the packet. If the incomplete packet is not corrected, the application cannot be processed.
- If the enrollment application is complete, the provider transaction will be processed.
 - If the IHCP confirms the provider's enrollment, the Provider Enrollment Unit will send a verification letter to the provider.
 - If the IHCP denies enrollment, the provider will receive a notification letter explaining the denial reason. If a provider believes their enrollment was denied in error, the provider may appeal. See the [Enrollment Denial or Rejection Appeal](#) section of this document for information.

Opioid Treatment Programs Enrolled as OPRs

Opioid treatment programs certified by the FSSA DMHA must be enrolled as IHCP providers. Opioid treatment programs (OTPs) can be enrolled as billing providers, as described in the [Addiction Services \(Type 35\)](#) section, or they can be enrolled as ordering, prescribing, or referring (OPR) providers. OTPs enrolled as OPR providers do not bill the IHCP for services, but may order, prescribe, or refer services and supplies for patients that are IHCP members, and the rendering provider would be reimbursed. Note that practitioners who work with opioid treatment programs and write orders, referrals, or prescriptions for IHCP members must also individually enroll with the IHCP for those services to be covered and reimbursed.

All OTPs enrolling with the IHCP (whether as OPR providers or as billing providers) are required to have a DEA license as well as certification from the DMHA.

Opioid treatment programs enrolled as OPRs are required by SEA 297 to maintain a memorandum of understanding with a community mental health center (CMHC) for the purpose of referring patients for services. Additionally, these opioid treatment programs are required to annually report information to the IHCP concerning members who receive services at their facilities. These reports must be filed by September 1 for the preceding fiscal year and must include:

- The number of Medicaid patients seen
- The services received by the program's Medicaid patients, including any drugs prescribed
- The number of Medicaid patients referred to other providers
- The other provider types to which the Medicaid patients were referred

Section 6: Provider Responsibilities and Restrictions

All providers must sign and abide by the *IHCP Provider Agreement*. The provider agreement is in force and legally binding for the entire program eligibility period.

Note: All providers have an obligation under federal civil rights laws to ensure access to services for members with limited English proficiency. See the [Introduction to the IHCP](#) module for instructions on posting information to demonstrate nondiscrimination compliance.

Updating Provider Information

It is the provider's responsibility to ensure that the enrollment information on file for that provider is complete and current, and to notify the IHCP of any changes within 30 business days of the change (10 business days for licensure, certification, or permit changes). Returned mail may cause termination of the provider's program eligibility, resulting in denials for reimbursement of services; therefore, it is very important to keep profile information updated, including address changes. Providers are required to submit all updates to their enrollment information either electronically, via the Portal, or by mail, using the appropriate enrollment packet or profile maintenance form. See the [Provider Profile Maintenance](#) section of this module for more information.

Screening for Excluded Individuals

All providers are obligated to screen potential employees and contractors to determine whether they are excluded individuals prior to hiring or contracting them and on a periodic basis thereafter. Additionally, providers are expected to review the calculation of overpayments paid to excluded individuals or entities by Medicaid. Federal law prohibits Medicaid payments from being made for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity that is excluded from participation – unless the claim for payment meets an exception listed in *42 CFR 1001.1901(c)*. Any such payments claimed for federal financial participation constitute an overpayment under sections *1903(d)(2)(A)* and *1903(i)(2)* of the *Social Security Act* and are therefore subject to recoupment.

The U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) maintains the List of Excluded Individuals and Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other federal healthcare programs. The [LEIE](#) is located on the HHS OIG website at oig.hhs.gov.

As a condition of enrollment, providers must agree to comply with the following obligations:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can access the LEIE database on the [HHS OIG website](#) at oig.hhs.gov and search by the name of any individual or entity.
- Search the HHS OIG website periodically to capture exclusions and reinstatements that have occurred since the last search.
- Report to the State any exclusion information discovered by contacting the Provider and Member Concern Line toll-free at 1-800-457-4515.

Maintaining Records

As outlined in 405 IAC 1-1.4-2, all providers participating in the IHCP must maintain such medical or other records, including x-rays, as are necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP. Providers must meet the following requirements:

- Records must be maintained for a period of 7 years from the date services are provided.

Note: A copy of a claim form submitted by the provider for reimbursement is not sufficient documentation to comply with this requirement. Providers must maintain records documented at the time the services are provided or rendered and prior to associated claim submission.

- Such medical or other records must be legible and must include, at the minimum, the following information and documentation:
 - Identity of the individual to whom service was rendered
 - Identity, including dated signature or initials, of the provider rendering the service
 - Identity, including dated signature or initials, and position of provider employee rendering the service, if applicable
 - Date that the service was rendered to the member
 - Diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only
 - A detailed statement describing services rendered, including duration of services rendered
 - The location at which the services were rendered
 - Amount claimed through the IHCP for each specific service rendered
 - Written evidence of physician involvement, including signature or initials, and personal patient evaluation to document the acute medical needs
 - When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals
When a member is enrolled in therapy, physician progress notes as to the necessity and effectiveness of therapy and ongoing evaluations to assess progress and redefine goals must be a part of the therapy documentation. The following information and documentation are to be included in the medical record:
 - Location (place of service code) at which services were rendered
 - Documentation of referrals and consultations
 - Documentation of test orders
 - Documentation of all services performed and billed
 - Documentation of medical necessity
 - Treatment plan
 - X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records
- Financial records must be maintained for a period of at least 3 years following submission of financial data to the IHCP. A provider must disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings.

Records maintained by providers are subject to prepayment and postpayment review and must be openly and fully disclosed and produced to the FSSA, ISDH, or authorized representative with reasonable notice and request. This notice and request can be made in person, in writing, or orally, although some situations may require a request to review records without notice.

Maintaining Licensure and Certification

All providers are required to be duly licensed, registered, or certified (405 IAC 5-1.4-3) to participate in the IHCP. IHCP Provider Enrollment uses a license verification process that includes all states' licensing board data to enhance provider information on file. Additionally, the IPLA submits monthly electronic provider license status reports to DXC. The status reports permit the Provider Enrollment Unit to deactivate providers that no longer have active or unrestricted licensure. Out-of-state licensing board websites are used to validate licensure and to ensure licensing information is current and in good standing for providers that render services in other states. Any provider that is not appropriately licensed in the state where services are rendered is not eligible for enrollment in the IHCP for payment of services.

Nonrenewed licenses are reported as expired or inactive on the IPLA reports. Providers listed on the reports are subject to deactivation. When a provider does not intend to renew a license, it is important to report the nonrenewal to the Provider Enrollment Unit as a disenrollment. The information must be reported on an [IHCP Provider Disenrollment Form](#), available at in.gov/medicaid/providers, or by using the Disenrollment link on the Portal.

If a provider is required to recertify, a notification is mailed to the provider 60 business days prior to the end date for program participation:

- Providers that fail to renew their program eligibility within 2 weeks after the recertification end date must submit a new IHCP enrollment application along with the new license information and all required supportive documentation. Providers can submit the application online through the Portal or complete and submit an enrollment packet, available on the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers.
- If a provider recertifies prior to the program eligibility end date, an update via the *Provider Maintenance* page of the Portal (or update via a recertification form) and any required documentation are all that is required to extend the program eligibility.

All transportation providers are required to recertify based on either their insurance end date or the motor carrier's certificate end date. If provider is required to have a surety bond, proof of surety bond is also required.

The following license statuses provided by State licensing agencies are the basis for deactivation of a provider's IHCP participation:

- Closed facility
- Deceased
- Expired
- Expired more than 3 years
- Inactive
- Null and void or error
- Retired
- Voluntary surrender
- Probationary licenses, which are subject to review for eligibility purposes

Lack of appropriate licensure affects a provider's ability to gain payment for services rendered after their license termination date. The IHCP end date is the same as the licensing board's termination or suspension date. The IHCP pursues collection of payments made to providers that bill for dates of service after their licensing board's termination or suspension date. Such notification does not negate the IHCP's ability to collect for dates of service paid to a provider whose license is not valid at the time services were rendered.

Substitute Physicians and *Locum Tenens*

Substitute physicians and *locum tenens* may fill in for a member's regular physician. The regular physician may be the member's primary care physician or primary medical provider (PMP), or a specialist that a member sees on a regular basis. The substitute physician or *locum tenens* must be the same discipline as the regular physician.

Substitute Physicians

A substitute physician is a physician who is asked by the regular physician to see a member in a reciprocal agreement when the regular physician is unavailable to see the member. A substitute physician may be asked to see a member if the regular physician is not available or on call. The substitute arrangement does not apply to physicians in the same medical group with claims submitted in the name of the medical group. In addition, a substitute physician arrangement should not exceed 14 days.

In a substitute physician arrangement, the regular physician reimburses the substitute physician by paying the substitute the amount received for the service rendered or reciprocates by providing the same service in return. In a substitute physician arrangement, the regular physician and the substitute physician must be enrolled as an IHCP provider. When procedure codes on the professional claim (*CMS-1500* claim form, 837P, or Portal professional claim) include the modifier Q5 to indicate that a substitute physician rendered the services.

Locum Tenens Physicians

Providers can create a *locum tenens* arrangement when the regular physician must leave his or her practice due to illness, vacation, or medical education opportunity and does not want to leave his or her patients without service during this period. Providers use the *locum tenens* arrangement in a single or a group practice, but the *locum tenens* physician cannot be a member of the group in which the regular physician is a member. The *locum tenens* physician usually has no practice of his or her own and moves from area to area as needed. The physician is usually paid a fixed per diem amount with the status of an independent contractor, not an employee.

The *locum tenens* physician must meet all the requirements for practice in Indiana, as well as all the hospital or other institutional credentialing requirements before providing services to IHCP members. The practitioner providing *locum tenens* services is not required to be an IHCP provider. The regular physician's office must maintain documentation of the *locum tenens* arrangement, including what services were rendered and when they were provided.

The regular physician's office personnel submit claims for the *locum tenens* services using the regular physician's NPI and modifier Q6 for applicable procedure codes.

Locum tenens arrangements should not exceed 90 consecutive days. If the physician is away from his or her practice for more than 90 days, a new *locum tenens* would be necessary. If a *locum tenens* provider remains in the same practice for more than 90 days, he or she must enroll as an IHCP provider.

Charging Members for Noncovered Services

Federal and state regulations prohibit providers from charging any IHCP member, or the family of a member, for any amount *not* paid for covered services following a reimbursement determination by the IHCP. See *Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15*; *Indiana Administrative Code, Title 405, Article 1, Rule 1, Sections 3(i)*.

Furthermore, the *IHCP Provider Agreement* contains the following provision:

To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with the federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.

The clear intent of this provision is to ensure that no member or family of a member is billed in excess of the amount paid by the IHCP for covered services.

As a condition of the provider's participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the Medicaid determination of payment, the provider's right of recourse is limited to an adjustment request, administrative review, and appeal as provided in *405 IAC 1-1-3*. Violation of this section constitutes grounds for the termination of the provider agreement and decertification of the provider, at the option of the FSSA.

Charging for Missed Appointments

IHCP providers *may not charge* IHCP members for missed appointments. The HHS based this policy on the reasoning that a missed appointment is not a distinct reimbursable service, but a part of the provider's overall costs of doing business. Furthermore, the Medicaid rate covers the cost of doing business, and providers may not impose separate charges on members. In addition, according to *405 IAC 5-25-2*, the IHCP will not reimburse a physician for missed appointments.

Charging for Copies or Transfers of Medical Records

IHCP providers are *not* permitted to charge for copies or transfers of medical records, including mailing costs. Federal regulation *42 CFR 447.15* states that providers participating in Medicaid must accept the State's reimbursement as payment in full (except that providers may charge for applicable deductibles, coinsurances, or copayments). The reimbursement for services is intended to cover the costs of medical record duplications or medical record transfers. Providers do not receive additional reimbursement from the State, or authorized agents for the State, for any cost associated with medical record duplications or medical record transfers.

The IHCP considers a physician who charges Medicaid patients for copying or transferring medical records to be in violation of this federal regulation and his or her *IHCP Provider Agreement*. Providers identified as showing a pattern of noncompliance with federal regulations and IHCP policy are subject to a Surveillance and Utilization Review (SUR) audit.

Member Billing Exceptions

An IHCP provider can bill an IHCP member for covered and **noncovered** services *only* when the following conditions are met:

- The IHCP member must understand, **before receiving the service**, that the service is not covered under the IHCP and that the member is responsible for the service charges. The provider must maintain documentation in the member's file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP. A provider may use a "waiver" form to document such notification; however, a "waiver" form is not required.

Note: If a waiver form is used to document that a member has been informed that a service is noncovered, the waiver must not include conditional language such as “if the service is not covered by the IHCP, or not authorized by the member’s PMP, the member is responsible for payment.” This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or PA as needed.

- The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists:
 - Only if separate codes exist can a noncovered embellishment be billed to the member and the basic charge billed to the IHCP. Otherwise, the service, in its entirety, is considered covered or noncovered.
 - *Example:* Because no separate procedure exists for embellishments to a standard pair of eyeglass frames, it is not allowable for the IHCP to be billed for the basic frames and for the member to be billed for additional charges. The entire charge for fancy frames is noncovered by the IHCP in accordance with the Covered Services Rule.
- A provider can bill the member in situations where the provider took appropriate action to ascertain and identify a responsible payer for a service.
- A provider can bill the member if the member failed to advise the provider of Medicaid eligibility. If the provider is notified of the member’s Medicaid eligibility within the timely filing limit (180 days for claims with dates of service or date of admission on or after January 1, 2019; 1 year for claims with dates of service or date of admission before January 1, 2019), the IHCP must be billed for the covered service. Any monies that were collected by the IHCP provider from the member must be reimbursed in full to the IHCP member.
- Documentation must be maintained in the file to establish that the member was billed or information requested within the timely filing limit.
- Providers can bill the member the amount credited to the member’s waiver liability as identified on the Remittance Advice following the final adjudication of the claim.
- Providers may bill a member if the service is not covered by the member’s benefit plan, such as services not related to family planning for Family Planning Eligibility Program members, and nonemergency services for to Package E (Emergency Services Only) members.
- Providers may bill a member when a service required prior authorization but the authorization was denied by the IHCP.
- Providers may bill a member for services that exceed a benefit limit when prior authorization is not available to receive additional services.

Note: Obtaining a signed waiver will not prevent IHCP from investigating the facts alleged in the waiver.

- A hospital can bill a member for services if the hospital’s utilization review (UR) committee established under 42 CFR 482.30 makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of 42 CFR 482.30(d), which states:

The determination that a continued stay is not medically necessary:

- I. *May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12 (c), concur with the determination or fail to present their views when afforded the opportunity; and*
- II. *Must be made by at least two members of the UR committee in all other cases. Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.*

- If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 business days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in *Section 482.12(c)*.
 - Before billing the patient, the provider must notify the patient or his or her healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.
 - Providers should consult with their attorneys or other advisors about any questions concerning their responsibilities in the UR process.

These guidelines apply to all members, regardless of their eligibility category or program.

Refusing or Restricting Services to Members

A provider can make a business decision not to provide a service to a member as long as the reason for doing so is not a violation of civil rights laws or the *Americans with Disabilities Act*. Providers can restrict the number of IHCP patients by any means, as long as their standards for limiting patients do not violate any statutes or regulations.

For example, *405 IAC 5-1-2* prohibits discrimination on the basis of “age, race, creed, color, national origin, sex, or handicap.” If the provider’s specialty is limited to patients of a certain age or sex, such as gynecology or pediatrics, that is permissible. If individual providers are unsure whether their standards or methods violate civil rights laws or any other laws, they must verify with their attorneys.

A sample nondiscrimination posting is included in the [Introduction to the IHCP](#) module. It addresses civil rights and prohibits discrimination when providing IHCP-covered services.

Solicitation, Fraud, and Other Prohibited Acts

Solicitation or a fraudulent, misleading, or coercive offer by a provider to supply a service to an IHCP member is prohibited as specified in *405 IAC 5-1-4*. Examples of provider solicitation include the following:

- Door-to-door solicitation
- Screenings of large or entire inpatient populations, except where such screenings are specifically mandated by law
- Any other type of inducement or solicitation to cause a member to receive a service that the member does not want or does not need

Note: Solicitation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services as specified in 405 IAC 5-15 does not violate the solicitation prohibitions in this section.

Providers are advised to be aware of federal penalties for fraudulent acts and false reporting as set out in *42 CFR Section 1396a*. For more details, see the [Provider and Member Utilization Review](#) module.